Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

The State and Territorial Guide to Substance Abuse Prevention in Declared Disasters

Implementation Guide

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention

The State and Territorial Guide to Substance Abuse Prevention in Declared Disasters

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Prevention
5600 Fishers Lane, Rockwall II
Rockville, Maryland 20857

Implementation Guide

This publication was prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), at the National Center for the Advancement of Prevention (NCAP). NCAP is a contract supported by SAMHSA/CSAP that is designed to advance substance abuse prevention practice through the synthesis and application of scientific knowledge.

The primary authors of this document were Tara Kelley Baker, M.S.W., Magdalena Hurwitz, and Paula Gordon, Ph.D. Beverlie Fallik, Ph.D., served as the Government Project Officer.

DHHS Publication No. (SMA) 97-3123
Printed 1997

Foreword

The Center for Substance Abuse Prevention (CSAP), as part of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, is the Nation's lead agency for improving the quality and availability of substance abuse prevention services.

SAMHSA/CSAP's Involvement in Disasters

CSAP and SAMHSA have been involved in efforts to minimize disaster-related substance abuse problems since the 1980s. As more State and grantee agencies have found themselves in the midst of declared disasters, the role of SAMHSA/CSAP in disaster-related substance abuse prevention has expanded. The most recent disasters in which SAMHSA/CSAP was involved were the 1995 bombing of a Federal building in Oklahoma City, the Los Angeles earthquake of 1994, the Midwest floods of 1993, and Hurricane Andrew in 1992. The increased emphasis on substance abuse prevention in relation to disasters has been augmented by efforts of the current administration and Congress to encourage most Federal agencies to be sensitive to the needs of States affected by natural and other declared disasters.

States and Territories bear major responsibility for guiding community organizations on matters regarding declared disasters. SAMHSA/CSAP has therefore addressed this *Guide* to State and Territorial authorities to help them provide guidance for community partnerships, demonstration grants, and community substance abuse prevention programs in the event of a disaster. SAMHSA/CSAP believes that State agencies, private organizations, and community systems that deal with substance use and abuse can play a vital role in ensuring that individuals and communities recover as quickly as possible from a disaster.

Generated by SAMHSA/CSAP's National Center for the Advancement of Prevention, this *Implementation Guide* provides case studies and practical checklists to use in planning for disaster response and recovery. It contains information on funding for disaster efforts and provides an overview of the theoretical models and approaches to substance abuse prevention in declared disasters.

SAMHSA/CSAP has provided this *Guide* to encourage State agencies and community organizations to take proactive steps for disaster planning that will, to the extent possible, prevent and minimize any associated substance abuse consequences.

It is hoped that this *Guide* will be helpful in stimulating and fostering cooperative initiatives and improving the effectiveness of State and community prevention efforts.

Nelba Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health Services Administration

Stephania J. O'Neill
Acting Director
Center for Substance Abuse Prevention,
Substance Abuse and Mental Health Services Administration

This guide was prepared prior to the retirement of Elaine M. Johnson, Ph.D., as Director, Center for Substance Abuse Prevention.

Contents

List of Tables

List of Figures

Acronym List

ADM	Alcohol, Drug Abuse, and Mental Health
CMHS	Center for Mental Health Services
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DHHS	Department of Health and Human Services
DoD	Department of Defense
EAP	Employee Assistance Program
FEMA	Federal Emergency Management Agency
HRS	Health and Rehabilitative Services (Florida)
NCADI	National Clearinghouse for Alcohol and Drug Information
NPN	National Prevention Network
NVOAD	National Volunteer Organizations Active in Disasters
PHS	Public Health Service
PREVline	Prevention Online
PSA	public service announcement
SAMHSA	Substance Abuse and Mental Health Services Administration
SSA	Single State Authority

INTRODUCTION

Disasters and Substance Abuse Prevention

Tropical Storm Alberto, 1994

The Florida Panhandle

A family of six was discovered in the front yard of its destroyed home. The four children were playing barefoot in mud that included, among other things, glass and dead snakes. The mother was sitting and crying quietly, and her husband was on the porch cursing a dead telephone. Neighbors told us that this family had been flooded out three times in the last four years and that the husband had developed a serious drinking problem since the last deluge.

—Work papers from the State of Florida Office of Health and Rehabilitation Services, 1994

In recent years, our country has been beset by a series of major disasters with immense and tragic consequences. Hurricanes, earthquakes, floods, civil unrest, and other disasters have resulted in devastation to individuals, families, and communities with far-reaching consequences above and beyond the initial injuries, loss of lives, and property damage. In the aftermath of such an event, the immediate devastation and the daunting task of rebuilding may make concerns about substance abuse seem relatively minor and remote. It is in this type of abnormally stressful circumstance, however, that substance abuse problems may arise, particularly as the initial crisis passes and survivors face the often long-term and tedious work of recovery. There are few statistics to indicate the dimensions of substance abuse problems related to the occurrence of disasters. However, the statistics that are available, along with reports from practitioners in the field, indicate that disasters can lead to

- ✎ Misuse of alcohol and drugs in response to the stress of disasters;
- ✎ Increase in problems often associated with substance abuse, such as family violence, suicide, and accidental injury;
- ✎ Breakdown of normal formal and informal controls that prevent substance abuse and related problems;

- ✎ Increased difficulties for people in recovery and those who may use alcohol and drugs excessively because of the additional stress associated with the disaster and the collapse of normal supports; and
- ✎ Increased vulnerability of children, youth, and the elderly to initiation or abuse of alcohol, tobacco, and drugs.

A UCLA psychiatrist, Dr. Louis West, coined the term "accumulated stress response" to describe a syndrome he observed in the aftermath of the 1994 Los Angeles earthquake and its aftershocks. Agitation, crying, use of alcohol and drugs, and impulsive, irrational behavior are some of the symptoms recorded. West noted that individuals' sense of stress accumulated with each successive aftershock. In another example, recurring and severe floods such as those experienced in the Midwest in 1993 led to extremely heightened levels of stress (as reported in *USA Today,* July 18, 1994).

Purpose and Orientation

The State and Territorial Guide to Substance Abuse Prevention in Declared Disasters has been prepared primarily for directors of State and Territorial substance abuse authorities and for State Prevention Coordinators. (References to "States" and "State authorities" throughout this *Guide* are intended to include Territories and Territorial authorities. Likewise, the term "Territory" or "Territorial authority" is intended to include not only official Territories of the United States but all jurisdictions that fall under U.S. authority.)

This *Guide* is designed to assist State and community substance abuse prevention systems in taking a lead role in maximizing prevention opportunities and minimizing negative substance abuse consequences, both of which may arise in a disaster and its aftermath. It does not, however, address special populations (such as the homeless, illegal aliens, or newly arrived immigrants), rapidly recurring disasters, or posttraumatic stress syndrome. Although these are pertinent issues today, it was not possible to include this level of information without lengthening the *Guide.* Information on these subjects can be found in supporting literature.

The dual objectives of maximizing prevention opportunities and minimizing negative substance abuse consequences reflect two premises that underlie all of the instructions presented in this *Guide.* The first premise is that agencies must maintain their own operations in a disaster in order to be able to help their constituencies. Instructions for obtaining funding and other forms of support are based on this premise. The second premise is that anything that helps meet basic needs and helps in coping with disaster-related stress is likely to prevent substance abuse. This premise leads to instructions that may appear, at first, to fall outside the purview of substance abuse prevention. It should be remembered, however, that substance abuse does not exist in isolation. It is closely related to other mental health issues—such as violence or depression—that may exist at any time but that are especially prevalent in the aftermath of a disaster.

It should also be noted that substance abuse difficulties may not become apparent until later in the recovery period of a disaster and that disaster plans can help set the stage or can help put systems in place to address these difficulties as they arise. The unpredictability of human responses to disaster makes preparation difficult but essential.

Knowing the roles, responsibilities, and resources needed to prevent disaster-related substance abuse can better prepare States, Territories, and communities to respond to a

disaster. A detailed and comprehensive planning effort will help to ensure that systems continue to function when disaster strikes.

The complexities of preparing and activating States, Territories, and communities are numerous and depend on many variables such as the size and severity of the disaster; whether a warning or alert is possible; whether warnings and broadcasts are heeded; the duration and intensity of the event; the number of people affected; the extent of property damage and losses, injuries, and casualties; the level of preparedness and response capability of the impacted geographic region; and the resources available to be directed at each stage of disaster management. Also, State and community roles and responsibilities blur as survivors and helpers struggle to respond. Nevertheless, the instructions in this *Guide* can help minimize a disaster's effects. The guidelines presented are based on the recognition that

- ✎ In the aftermath of a disaster, an increase in substance abuse accompanies a general upsurge in maladaptive behavior, sometimes as a contributing cause and sometimes as a result.
- ✎ Addressing the basic survival needs and other factors contributing to an increase in unhealthy behavior in the disaster aftermath will help inhibit the rise of substance abuse.
- ✎ The objective of all disaster-related efforts is to restore and renew the support systems that serve as the basis for social interaction in the area or region, while paying particular attention to cultural and linguistic appropriateness.
- ✎ Disaster preparedness comprises the best strategy for effective disaster-related substance abuse prevention.

This *Guide* realistically cannot anticipate all circumstances that States, Territories, and communities may face. Rather, the *Guide* and the resources presented in Chapter 5, "Funding," offer a starting point for tailoring optimal approaches to substance abuse disaster management.

How To Use This Guide

This *Guide* is based on available literature, information from current national disaster-related programs, and interviews with scores of State and local prevention practitioners with real experience in declared disasters. Since disasters vary widely, the optimum responses to disaster-related substance abuse prevention activities and approaches will also vary. The intent of this *Guide* is to present general principles that can be adapted by States and Territories.

Chapter 1: Substance Abuse-Related Disaster Management

Chapter 1 presents a case study of a recent disaster and summarizes the lessons learned during the relief effort and other recent disaster efforts. The issues raised in this account are intended to provide a context for the recommendations that follow in subsequent chapters. Chapter 1 also introduces the framework for disaster management detailing the phases of preparedness, response, and recovery.

Chapter 2: Disaster Preparedness—*Lessening the Effects of Disaster*

Chapter 2 uses another case study to present the goals, strategies, action steps, and resources that States, Territories, and community organizations can employ to prepare for a disaster. Recommendations are designed to help States/Territories and community organizations make plans that will maximize prevention opportunities and minimize the potential for substance abuse in the event of a disaster.

Chapter 3: Disaster Response—*Providing Remedial Assistance*

Chapter 3 encourages substance abuse service providers to cooperate and coordinate with the providers of emergency services who will be the primary players in the immediate aftermath of a disaster. During the disaster response phase, the definition of substance abuse prevention may be expanded to include all activities that minimize loss of life, personal injury, or destruction of property.

Chapter 4: Disaster Recovery—*Returning Systems to Normal*

Chapter 4 discusses the arduous process of disaster recovery, the phase where most substance abuse becomes apparent. A discussion of the disaster survivor is intended to help substance abuse service providers understand the human consequences of disaster. The goals, strategies, action steps, and resources available to States/Territories and community organizations are detailed.

Chapter 5: Funding—*Obtaining Funding Assistance*

Chapter 5 deals with funding sources. The discussion includes eligibility requirements and application procedures for obtaining funding through various Federal agencies.

Disaster Checklists

The checklists that appear after Chapter 5 summarize the action steps that have been presented throughout this *Guide.* State- and community-level substance abuse service providers can use these checklists to assess their organizations' preparedness. Organizations that identify gaps in their disaster planning are encouraged to review the appropriate sections in the *Guide* to find suggestions for filling those gaps.

Appendix

The *Guide* ends with an appendix, which presents theoretical approaches to understanding disaster-related human behavior.

DISASTER MANAGEMENT

1. Substance Abuse-Related Disaster Management

Introduction to a Disaster

One large-scale natural disaster generated this case study involving the Single State Authority (SSA) for alcohol and drugs and local governmental organizations. Although presented from the SSA viewpoint, this study provides a critical look at the potential and real contributions to be made by substance abuse agencies and the barriers created by insufficient planning. The lessons learned from this disaster and others discussed in this *Guide* help frame the critical questions for this document.

> On Monday, August 24, 1992, at 4:52 a.m., Hurricane Andrew made landfall in south Dade County, Florida, leaving a 30-mile-wide path of devastation in its wake. Within the hour, 42 lives were lost and 250,000 people became homeless. Other figures from the Federal Emergency Management Agency put the number of homes destroyed at 90,000, with an even greater additional number damaged, and thousands of businesses demolished. The total property loss was estimated to be more than $30 billion.
>
> While downed electrical and telephone lines and cellular towers made immediate assessment of the disaster's full impact difficult, it was clear to the decisionmakers in south Dade that State and Federal assistance of great magnitude would be necessary. Contributing further to this need was the fact that many of the State authority and service provider staff were themselves victims of the hurricane and were therefore, at least initially, unable to render assistance to others.
>
> More than 60 licensed substance abuse prevention and treatment programs had been operating in southern Florida's Dade and Monroe counties. More than 20,000 clients had been admitted to these programs for treatment in the year preceding Hurricane Andrew. Tens of thousands more received substance abuse prevention services. This disaster exacerbated the already dire shortage of substance abuse services in the southern area of the State. The overtaxed substance abuse service system had registered its 775th client on the substance abuse treatment waiting list the day before the hurricane hit. After Andrew, four of the larger substance abuse service

agencies were virtually annihilated, including one with a daily census of 1,500 people. Dade County immediately shut down its only detoxification program to use the facility as a shelter for hurricane survivors.

Programs focusing on primary prevention before the hurricane were obliged to temporarily shift their general awareness and educational strategies to providing targeted prevention strategies and relapse prevention services. The shift proved difficult due to the lack of prior training and experience in the strategies and populations among some of the primary preventionists. A second difficulty arose as these more costly efforts were called for at a time when resources were least available.

Other disaster events and conditions indicated that the involvement of staff from the State Alcohol, Drug Abuse, and Mental Health (ADM) program office would be critical to disaster relief and recovery. These included

- ✎ The destruction of schools acting as community bases for programs aimed at substance abuse prevention;
- ✎ The increased potential for disaster-related substance abuse among impacted families and caregivers;
- ✎ The change of focus for traditional substance abuse programs to include a broader range of activities in direct response to the disaster;
- ✎ The increased responsibility of local human service agencies for children and families in spite of the destruction of several field offices; and
- ✎ The need for acute care to respond to the withdrawal symptoms in people addicted to drugs or alcohol whose supply was unexpectedly and rapidly disrupted.

Within 48 hours, the State of Florida's health and social service agency, the Department of Health and Rehabilitative Services (HRS), had mobilized its many divisions including the SSA for substance abuse housed within the ADM program office.

Key staff from the SSA, the larger ADM program office, and the State and substate district levels were immediately dispatched to south Florida. Key employees of the local ADM service system were asked to report to the nearest State authority service center by way of a plea issued on the radio from their authority's Secretary. For most of these employees, however, responding to this plea was made impossible by continuing hazards and restraints such as downed electrical lines, impassable roads, and the restrictions on travel enforced by armed National Guardsmen charged with keeping order and protecting areas from looting.

Nevertheless, staff members prepared themselves to assist with disaster-related substance abuse and mental health problems. Unex-

pectedly, however, their initial and sustained responsibilities involved coordinating teams of volunteers and service providers to help meet the basic needs of the disaster survivors, such as helping people find water, food, medical care, daycare, and supplies. The ADM leaders decided to collocate at the central command post where Federal, military, and other disaster response efforts were being coordinated, and to deploy their teams from there. This spur-of-the-moment decision enhanced the communications necessary for optimal service coordination. At any given time, ten teams of four to eight people with substance abuse prevention and mental health care experience were deployed to help survivors meet basic needs.

Other SSA staff flew to the site to meet with substate district staff and local service providers to attempt to determine the extent of lost substance abuse service capacity and the resources needed for response and recovery efforts. The lack of prenegotiated policies addressing disaster-related services and reimbursement rates resulted in conflicts and delays and added to the tensions and stress. Major reductions in expected Medicaid reimbursements were attributed to lost substance abuse service capacity. While some disaster-impacted substance abuse programs received funds from sources that were sufficiently flexible to bridge the gaps in service caused by the disaster, programs that relied heavily on Medicaid funds became additionally vulnerable.

At the SSA office, staff wrote emergency grant applications for substance abuse disaster funding. Efforts were hampered as grant writers tried to determine which disaster response and recovery expenses could be reimbursed from various funding sources (including Federal disaster funding). Funding for fixed capital outlay was especially needed but hard to find. Because this reimbursement and funding information had not been gathered prior to the disaster, critical response time was lost to fact-finding tasks that could have been done beforehand. Additional delays were caused by disruptions in telecommunications services. SSA staff were forced to estimate the disaster's impact on service and funding needs.

Further contributing to the lack of response capacity was the absence of a statewide or substate needs assessment. The SSA was thus unable to forecast substance abuse needs that could arise during long-term recovery. For example, no one had anticipated the demands placed on the substance abuse prevention and treatment network and other social services and housing systems from the hundreds of transient workers and their families who came to south Florida to volunteer or provide temporary construction and other labor.

Local attempts to secure temporary buildings (mobile homes and modular buildings) to house substance abuse prevention and treatment services after the disaster were thwarted by other organizations with better access to funding. Staff also had to research local zoning

ordinances to make temporary substance abuse service placement decisions, and disaster reimbursement guidelines had to be checked to determine the policies for purchasing temporary structures.

As recovery efforts continued, a dramatic shift occurred in the demography in south Florida. A new set of demographic variables took precedence in substance abuse prevention and epidemiology efforts. These variables included housed/nonhoused, insured/noninsured, and employed/employment disrupted.

It became clear to local prevention workers that the most efficient substance abuse response following a disaster can occur through community coalitions. While the south Dade area was in the process of strengthening its prevention network prior to Hurricane Andrew, the Miami area had a fairly strong prevention network already in place to assist south Dade in response and recovery efforts. The members of the Miami area prevention network had worked together on other projects and knew what programs, resources, and skills could be drawn upon after the disaster.

Lessons Learned

This case study illustrates what can happen when no predisaster plans exist. During the first few days after the disaster, the SSA was able to respond by mobilizing staff, selecting a command post, assessing damage and the need for additional substance abuse prevention resources, and providing survivors with help in meeting basic needs. However, these efforts were hampered because the absence of a disaster plan led to the loss of critical response time.

The SSA learned that the State of Florida needed to design a plan to include

- ✎ An emergency communications system,
- ✎ Preauthorization for full access to the disaster area,
- ✎ A prearranged command post and staffing pattern,
- ✎ Prepared grant applications,
- ✎ Preidentified funding sources,
- ✎ Prenegotiated reimbursement rates,
- ✎ Alternative office space, and
- ✎ Knowledge of zoning ordinances.

The failure to plan also impeded the SSA's work in addressing the longer term needs of disaster recovery. Activities such as providing more substance abuse-specific services to those in need, reinforcing connections with other community groups working with survivors, and writing a postdisaster assessment of the agency's performance were more difficult and time-consuming because the SSA lacked a sound predisaster plan.

Many lessons became obvious after south Florida's experience with Hurricane Andrew and after other recent disasters such as the Northridge earthquake in California in 1994, the Midwest floods in 1993, the East Bay Hills fire in Oakland, California, in 1991, and the South Central Los Angeles Riots in 1992. These lessons included

- ✎ That those in key roles of responsibility in disaster response and recovery efforts may not be adequately prepared in the event of a disaster;
- ✎ That preventionists need training to prepare them for the shifting and reordering of priorities and strategies;
- ✎ That prevention programs that are very categorical in nature (e.g., a very narrow focus on eighth grade inhalant users) often lack the flexibility and adaptability needed in a disaster to address the broader range of substance abuse prevention and related needs;
- ✎ That order may not be restored quickly in complex and chaotic situations, and that rationality and orderly actions are much harder to achieve in the aftermath of a disaster;
- ✎ That bureaucratic processes existing before a disaster usually cannot be bypassed or expedited in a disaster;
- ✎ That grant applications for obtaining Federal disaster relief funding should be drafted in advance;
- ✎ That other funding sources need to be located for various services and items;
- ✎ That policies should be developed to define disaster-related service units and corresponding reimbursement rates;
- ✎ That alerts for cultural and ethnic helpers representing different groups should be sent out across the State to assist in providing services to diverse population groups;
- ✎ That arrangements for necessary vaccinations, such as tetanus shots, should be made for all substance abuse prevention workers, volunteers, and caregivers;
- ✎ That, in the absence of adequate substance abuse-related disaster preparation, crisis response training needs to be developed and delivered quickly;
- ✎ That planning is needed to make living arrangements for transient workers and to deal with the substance abuse prevention, intervention, and treatment needs of a large temporary workforce;
- ✎ That methods for overcoming disruption of normal public services (such as transportation and telephone service) should be identified and used; and
- ✎ That zoning ordinances must be researched to determine if modular buildings and mobile homes can be quickly put in place to provide interim substance abuse prevention and treatment services (particularly residential care).

The aftermath of several severe natural disasters over the past few years has made it painfully clear that there needs to be a central substance abuse-specific disaster plan in place, in order for States and communities to respond quickly and comprehensively to aid victims of such events. This plan should address such critical elements as communications, preauthorizations for area access and grant applications, logistics and facilities, zoning ordinances, funding sources, and training of support personnel/volunteers. Once established, a disaster plan will enable organizations like the SSA to mobilize staff and resources to meet both immediate and long-term needs.

The following section introduces a disaster management framework outlined by the Federal Emergency Management Agency (FEMA), the primary Federal agency responsible for responding to large-scale disasters.

Phases of Disaster Management

The phases of disaster management developed by FEMA have been adapted in this *Guide* to provide a useful framework for understanding, developing, and implementing optimal strategies in managing substance abuse prevention in disasters. It is helpful to view disaster management activity as composed of three phases: preparedness, response, and recovery. Table 1 defines these phases. It is important to note that State and community substance abuse prevention agencies and organizations bear distinct responsibilities during Phase 1 and Phase 3. During Phase 2, State and community responsibilities merge as everyone responds to the immediate aftermath of the disaster.

Table 1. Phases of Disaster Management

Phase 1	Preparedness	This phase encompasses (1) all predisaster activities to be undertaken long before a disaster occurs, to lessen its effects, and (2) activities that lay the immediate groundwork for response and recovery operations.
Phase 2	Response	This phase includes the first 3 weeks after a disaster, during which emergency assistance is provided.
Phase 3	Recovery	This phase extends from 2 weeks to several years after the disaster, as attempts are made to return systems to normal. In some substance abuse situations, conditions may even be improved.

Note: Although response and recovery can be conceived of as phases, the ending of the response phase often blends with the beginning of recovery, and the actual duration of either phase may vary depending on the nature of the disaster and the community.

Table 2 charts the goals, strategies and action steps, and resources available to State and community substance abuse prevention agencies and organizations during each phase of disaster management.

The next three chapters contain detailed information for each phase of disaster management. Sections within each chapter provide general substance abuse disaster-related goals and objectives and strategies and action steps and discuss resource utilization and allocation. More specific details for States and community organizations are also covered, including

- ✎ The types of substance abuse-specific assistance that can reasonably be provided during the response and recovery efforts;
- ✎ The qualities and skills needed in volunteers and caregivers;
- ✎ The functions these helpers can perform;
- ✎ The types of training needed to prepare the substance abuse system to plan for disaster response and recovery; and
- ✎ The reimbursement policies needed to support funding requests and substance abuse service providers whose services become disrupted or significantly altered by the disaster.

Table 2. Matrix of Substance Abuse-Related Disaster Management

		Goals	Strategies and Action Steps	Resource Utilization
PREPAREDNESS	State		Assess State agency planning needs. Encourage substate regions and communities to develop their disaster plans. Become familiar with State mass care plans. Network with treatment providers to establish continuing care. Work with tribal leaders within individual State jurisdictions.	Develop funding transfer mechanisms. Develop substance abuse service units and reimbursement policies and rates. Draft grant applications for disaster funding. Gather information about predisaster substance use baseline levels. Learn which agencies may be called upon to provide grants for financial support. Determine locations where documentation can be stored safely. Utilize DoD initiative for surplus equipment.
	Combined	To develop comprehensive substance abuse disaster plans at their respective levels that detail strategies, action steps, and human and fiscal resources.	Gather information regarding responsible Federal and State agencies and their plans. Coordinate and integrate substance abuse disaster plans with existing general services disaster plans. Develop formal agreements and address turf issues. Identify and involve community stakeholders in development of substance abuse disaster plan. Ensure appropriate service delivery. Establish emergency communications systems. Locate funding sources.	
	Community		Assess potential community needs for recovery. Develop community substance abuse prevention training. Develop protocols for delivery with volunteers. Educate local law enforcement officials. Encourage individuals and families to develop their personal disaster plans. Develop local ordinances. Become familiar with U.S. Army relief terms and infrastructure.	Contact SSA to procure equipment, literature, and other disaster resources. Develop mutual aid agreements with other community organizations.

Table 2. Matrix of Substance Abuse-Related Disaster Management (Continued)

		Goals	Strategies and Action Steps	Resource Utilization
RESPONSE	State		Recruit disaster relief and outreach workers to provide culturally appropriate services. Involve prevention leaders in damage assessment process. Begin disaster assistance application process. Help substance abuse workers stay informed about relief and recovery efforts.	Seek support from other States.
	Combined	To facilitate and coordinate substance abuse prevention response efforts with other disaster response efforts.		Seek assistance from these major organizations: ✎ FEMA ✎ U.S. Army ✎ National Guard ✎ Red Cross ✎ Media ✎ NVOAD ✎ State Dept. of Public Safety
	Community		If possible, plug into Federal and State efforts. Care for personal needs.	Seek support from other communities.

Table 2. Matrix of Substance Abuse-Related Disaster Management (Continued)

		Goals	Strategies and Action Steps	Resource Utilization
RECOVERY	State	To provide communities with support.	Initiate and maintain regular contact with community and continue to provide guidance and support in renewing general and substance abuse community services. Begin to turn over appropriate substance abuse prevention responsibilities to communities.	Act as a conduit for distributing Federal funds to communities.
	Combined		Provide contact with appropriate preventionist personnel. Increase outreach services. Match substance abuse preventionists with other mental health professionals.	Apply to these agencies for funding assistance: ✎ FEMA ✎ CSAT ✎ SAMHSA/CSAP
	Community	To use SSA support to supplement and foster community substance abuse prevention efforts.	Educate community staff volunteers to the potential for substance abuse problems. Activate plans to respond to disaster-related substance abuse problems. Find locations for service delivery, outreach, and referral. Identify individuals at risk and refer them to the appropriate agencies. Promote alternatives to substance use. Reduce sense of stigma in seeking services. Distribute alcohol, tobacco, and drug information. Watch for and avoid staff and volunteer burnout.	Work with the following groups and organizations: ✎ Volunteers ✎ Schools ✎ Faith community ✎ Businesses and corporations ✎ Department of Parks and Recreation ✎ Other communities ✎ CMHS ✎ Media and information system providers

Note: More detailed information is provided in the checklists following Chapter 5 of this *Guide*.

2. Disaster Preparedness—
Lessening the Effects of Disaster

Under Federal mandate, U.S. States and Territories have established focal points for disaster preparedness within their jurisdictions. However, the sophistication and comprehensiveness of disaster readiness among and within State and Territorial governments may vary greatly over time because changes are constantly being made in legislation, regulations, procedures, resources, and capacities. Organizational and political realities in one disaster have not necessarily held true in another, even when the second disaster has occurred in the same State or Territory. Roles and responsibilities have been carried out in widely varying ways in recent disasters.

This chapter, which begins with a case study presenting ideal State actions to lessen the effects of a disaster, provides goals, strategies and action steps, and resources that State/Territory and community substance abuse agencies and organizations can undertake and put together before a disaster strikes. By making use of this information, substance abuse preventionists can better ensure that their disaster-related State/Territory and community efforts will achieve optimal effectiveness.

State Action: A Case Study

Few State or local substance abuse prevention organizations have had the opportunity to develop a comprehensive substance abuse disaster plan. The following fictionalized case study, based on a real event, demonstrates how preparedness efforts can greatly enhance disaster response and recovery. Please note the differences between this and the Florida case study presented in Chapter 1.

> Late in the evening, the Hawaii substance abuse SSA and the National Prevention Network (NPN) representative were summoned to an emergency meeting of the Governor's disaster preparedness team to begin activating the State's disaster plan. Hurricane Iniki, which had been watched carefully all day, had changed course toward the Hawaiian Islands. Incidents of rough waves washing ashore with minor damage were reported. Although still unsure of Iniki's precise destination, local residents were stocking up on emergency supplies.
>
> The SSA and the NPN representative had been involved months earlier in developing a detailed disaster-response plan with the State

and substate substance abuse service providers and community partnerships. This plan involved a good representation of substance abuse service stakeholders and had been well coordinated with Hawaii's primary disaster plan. Roles and responsibilities had been predetermined; crisis response training had been developed and provided; and the substance abuse response capacity was sufficiently diverse to meet the needs of disaster survivors, regardless of gender, race, ethnicity, culture, physical challenges, or age. Emergency equipment from closed military bases had already been procured through the Department of Defense (DoD) initiative earmarking surplus equipment, free of charge, to State substance abuse systems. First aid kits, communication devices, and vans equipped for mobile outreach stood ready for use.

After the emergency meeting, the NPN representative telephoned the local media and sent fax transmissions to release public service announcements (PSAs). These announcements were based on PSAs taken from a SAMHSA/CSAP technical assistance package that had been distributed via PREVline and adapted as part of the local disaster media package. The PSAs were targeted to give helpful information and varied in length from 15 seconds to 1 minute. Examples included

- ✎ How parents might explain to their children the effects of a hurricane, safety procedures, and appropriate coping mechanisms;
- ✎ Special news stories about how alcohol and tobacco providers should ensure no access for minors to their products during the aftermath of a disaster; and
- ✎ Messages about traditional cultural resiliency factors that could help communities in time of a disaster; and
- ✎ Health messages about the need to have a clear mind in times of emergency, including how alcohol and drugs can interfere with judgment and reaction time.

The State substance abuse director and NPN representative then sent an emergency fax transmission to treatment centers and hospitals reminding them of the medical protocol developed during the planning process that addressed detoxification procedures for substance abusers whose supply had been unexpectedly interrupted.

The NPN representative distributed emergency packets on obtaining assistance during a state of emergency, including predetermined disaster-related substance abuse reimbursement procedures. All of this information was faxed to substance abuse providers in the expected disaster area while communication was still possible. Those members of the substance abuse disaster team from areas not expected to be impacted were asked to be available for transport to the affected area. In addition, the NPN representative checked to make sure that information developed earlier for a template grant application was located in a safe, waterproof location.

> The next morning, it was apparent that Hurricane Iniki was headed for the Hawaiian Islands. With all plans activated and teams on notice, there was nothing to do but tune in to television news programs broadcasting the speed and direction of the hurricane. All nonessential staff were sent home to be with their families, and the directors evacuated to the emergency command shelter. In the early afternoon, it was clear that the island of Oahu was going to be spared, but Iniki moved directly over the island of Kauai, hitting the island with full force.

This brief case study illustrates several State/Territory disaster preparedness strategies and action steps and sets the stage for this chapter, which presents a practical framework and specific steps for State and community substance abuse service agencies and organizations to undertake during the disaster preparedness phase.

Goals and Objectives for Disaster Preparedness

States, Territories, and communities share a common goal in substance abuse disaster efforts: to develop comprehensive disaster preparedness plans at their respective levels that detail strategies, action steps, and human and fiscal resources to be used to prevent and minimize substance abuse problems in large-scale disasters.

SAMHSA/CSAP urges State and Territorial substance abuse authorities and community organizations to use the information in this *Guide* to

- ✎ Create and develop a substance abuse disaster plan,
- ✎ Annually review and update disaster plans, and
- ✎ Regularly conduct simulation exercises.

A substance abuse disaster plan can be used to set the foundation for action, to identify key principles and values, and to strengthen positive and effective attitudes.

Strategies and Action Steps for Disaster Preparedness

The basic strategies and action steps listed in this section apply to both States and communities. These should be included in an effective substance abuse disaster plan developed with input from organizations and individuals who will be critical for its implementation. The basic planning activities presented combine the lessons learned from Hurricane Andrew in Florida and analyses of earlier disaster responses, especially the detailed study undertaken after the 1991 East Bay Hills fires in California (Gordon and Maida 1992). Strategies and action steps derived from all of these experiences include

- ✎ Gather information regarding responsible Federal, State, and local agencies and their disaster plans.
  - — Identify the national, State, and Federal agencies and organizations responsible for emergency management.
  - — Acquire relevant information from these organizations regarding their roles and responsibilities in disaster response and recovery. It is suggested that States gather the information and distribute it to their communities.

- Clarify authorities, roles, and responsibilities of various service agencies beforehand, so that during a disaster key workers can gain access to shelters, disaster assistance centers, and other locations where access currently is limited to emergency services personnel. To assist in this clarification, substance abuse service agencies, public mental health agencies, and nonprofit counseling organizations should distinguish their individual jurisdictions, roles, and activities.

✎ Coordinate and integrate services.

- Find out what emergency plans exist at the appropriate level (State/Territory and local government) and coordinate the development of the substance abuse disaster plan with these existing plans.
- Work with mental health and other crisis services to develop a coordinated and integrated area disaster plan. Coordination and integration will enable organizations responding to the disaster to provide effective resource allocation and service delivery, especially in the immediate aftermath when substance abuse workers may be concerned with providing a broader array of services, such as
  - ✎ Individual services, case management, and household advocacy;
  - ✎ Outreach, home visits, and aftercare;
  - ✎ Planning for children's needs and services to schools;
  - ✎ Practical survivor assistance and advocacy;
  - ✎ Public information services; and
  - ✎ Debriefing and support for crisis intervention workers.
- Identify agencies that (1) will take the lead in disaster mobilization and (2) will be primarily responsible for ensuring full access to underserved and vulnerable populations during the emergency.

✎ Develop formal agreements and address turf issues.

- Service provider agencies and organizations should have formal agreements concerning mutual assistance, communications, roles, and responsibilities. Waiting to create such working relationships after a disaster has made past recovery efforts more difficult.
- Political, jurisdictional, and other "turf" issues need to be understood and addressed in advance. The planning period can also provide opportunities for other helping professionals to be trained by substance abuse workers to identify and refer individuals with substance abuse problems.

✎ Identify and include key stakeholders in the development of the substance abuse disaster plan, including

- Community partnerships, coalitions, and systems;
- Representatives from other groups; and
- Local service providers.

✎ Involve all population and community groups in substance abuse disaster training and recruitment efforts to ensure inclusiveness and knowledge of ethnic and

cultural needs, as well as special needs of other groups such as the elderly and children.

- ✎ Ensure appropriate service delivery.
  - — Assess which populations are the most vulnerable to substance abuse and where they might receive services most effectively.
  - — Determine which personnel and possible backups are to be assigned.
  - — Provide comprehensive information to key workers about service availability.
  - — Plan for integrated service delivery with existing community institutions, such as the PTA and senior citizens centers.
- ✎ Establish emergency communications systems.
  - — Understand the emergency communications problems in past disasters and obtain technical assistance to make improvements in current emergency communications capabilities.
  - — If there is time for a disaster warning, set aside a secure phone line to be used exclusively by disaster survivors.
- ✎ Locate funding sources.
  - — Funding sources for disaster-related efforts ideally should support both short- and long-term prevention programs to be implemented after the disaster. (See Chapter 5, "Funding.")
  - — Resources for funding, technical assistance, supplies and equipment, and mutual aid should be predetermined, and linkages should be created for ready access in the event of a disaster.

Strategies and Action Steps for State/Territory Preparedness

State and Territorial substance abuse authorities should specifically consider the following strategies and action steps:

- ✎ Assess State authority planning needs. Consider the following questions:
  - — Do State and local substance abuse agencies and organizations know the resources available to them to assist with substance abuse-related disaster management?
  - — Have State and local substance abuse agencies and organizations sufficiently cross-trained volunteers, substance abuse service providers, and other caregivers and provided them with the skills needed to participate in disaster preparedness, response, and recovery?
  - — Is this human resource capacity responsive to diversities in gender, age, race, ethnicity, culture, and physical and mental abilities?
  - — Who are the specific key players and service systems that should be involved in disaster preparedness, response, and recovery?
- ✎ Encourage substate regions and communities to develop substance abuse disaster plans as part of their existing and routine planning process. SSAs can add further

authority-specific information to State- and Federal-level disaster information and offer technical assistance as well.

- ✎ Become familiar with State/Territorial policies addressing various mass care plans such as the use of tent cities, prefabricated structures including mobile homes, and mobile outreach vehicles. These policies may ultimately determine the method of substance abuse service provision after a disaster.
- ✎ Network with treatment providers and arrange for continuing care that may be necessary in the event of an emergency.
- ✎ Work with tribal leaders of Native American communities to develop policies and procedures for mutual assistance.

Strategies and Action Steps for Community Preparedness

- ✎ Assess potential community needs and consider the following questions to develop an effective disaster-related substance abuse prevention plan. These considerations include
  - — Have the survivors experienced a catastrophic event in the recent past?
  - — Is there any past experience that reminds the survivors that they will get through this disaster, too?
  - — Is there a "sense of community"?
  - — Is the community dispersed over large areas that are urban, suburban, rural, or transitory?
  - — Is the area at high risk due to crime, poverty, unemployment, mental illness, or homelessness?
  - — What are the demographics of the affected communities?
  - — What resources are available, and what service gaps are likely to occur in localities due to their differing socioeconomic characteristics?
- ✎ Develop community substance abuse training activities for relief and recovery workers that focus on disaster outreach and referral using communication techniques learned from substance abuse prevention. Training of this type is critical because substance abuse outreach and referral skills will be used extensively after a disaster.
- ✎ Train health care practitioners to be alert for an increase in requests for prescription medication and to be aware that, following a disaster, individuals who use prescription drugs are at increased risk for abuse of these medications.
- ✎ Develop protocols for dealing with volunteers. A number of special issues surround the use of licensed health, mental health, and social service professionals in volunteer roles, and their solutions will depend upon individual State and local regulations. (For more information on special issues refer to Chapter 4, "Disaster Recovery.")
- ✎ Establish protocols for dealing with the challenges and ethical dilemmas facing service providers in a disaster, including the following:
  - — Difficulties in adhering to the code of ethics in the midst of chaos;

- — Difficulties in recordkeeping, obtaining informed consent, and maintaining confidentiality in extreme circumstances; and
- — Providing counsel outside one's area of expertise (American Psychological Association 1994*b*).

✎ Become familiar with licensing issues. Licensed mental health professionals who cross State lines to work on disaster sites must be aware of licensing laws. Many States do not permit out-of-State mental health professionals to practice, even in a disaster situation (Ofman 1994).

✎ Establish pro bono policies. Some licensed professionals may feel that the most appropriate role for them is to serve as an educational resource and refer people to professional help rather than give specific advice on a pro bono basis (American Psychological Association 1994*a*).

✎ Educate local law enforcement officials about reducing community substance abuse risk by controlling the availability and access to alcohol and drugs in a disaster aftermath.

✎ Encourage individuals and families to develop personal disaster response plans.

- — Broadcast and publish public service announcements encouraging individuals and families to learn from the American Red Cross and develop adequate personal disaster response plans.
- — Establish procedures for helping families plan for pet caretaking. If families know their pets will be taken care of and safe, they will be more likely to leave unsafe housing structures and seek shelter and other needed services.

✎ Consider developing local ordinances for temporary implementation during a disaster that address availability and control issues.

✎ Become familiar with U.S. Army terms and infrastructure to reduce any potential confusion between Army relief workers and substance abuse agency staff.

Resource Utilization for Disaster Preparedness

Resource Utilization for State/Territory Preparedness

During this phase, States/Territories and communities usually work in parallel, rather than by combining forces. States can maximize utilization of available resources in the ways listed below. Details on funding appear in Chapter 5.

✎ Develop a contract or other funding transfer mechanism between the SSA office and the designated State/Territory authority that will act as the fiscal agent for Federal and State disaster funding (e.g., in Florida it is the Department of Community Affairs). Having these arrangements in place before a disaster strikes saves valuable response time after a disaster.

✎ Develop disaster-related substance abuse service units and corresponding reimbursement rates. Develop sample contract language to use in substance abuse provider contracts to facilitate delivery and reimbursement. Develop protocols about if or how substance abuse disaster services can be delivered and reimbursed to nontraditional providers with whom no State/Territory contracts exist.

- ✎ Create a draft grant application for disaster relief funding to be readily revised and submitted after a disaster has been declared. This document can be partially prepared by creating a grant framework and narrative while leaving the impact statements blank to be filled in when known. Be prepared to include the impacts of substance abuse needs of transient workers engaged in postdisaster rebuilding efforts.
- ✎ Gather as much information as possible about the predisaster baseline of substance abuse levels to establish the rationale for funding needed for postdisaster increases in substance abuse. Archival data can be gathered to form a baseline including: alcohol- and drug-related arrest data; sales taxes collected on alcohol and tobacco products; school dropout rates; alcohol- and drug-related traffic fatalities; and substance abuse-related emergency room visits. Substance abuse prevention and treatment service records or needs assessment data can also help provide justification.
- ✎ Learn which local, State, and Federal agencies can provide grants for financial support and what specific data and documentation are required.
- ✎ Determine at least three "safe" locations where all disaster response and recovery documentation can be stored in the event that the SSA is not functioning. Such a location can be in waterproof and fireproof files or, possibly, in a nearby town or city. If there is time for disaster warnings to be issued, documentation can then be moved to its emergency location.
- ✎ Take advantage of the DoD initiative that makes surplus equipment available for State substance abuse authorities through CSAT's Division of State Programs (phone: 301-443-3820). Work with communities before a disaster occurs to assess what and how much equipment might be needed.

Resource Utilization for Community Preparedness

Along with implementing strategies parallel to those undertaken by States/Territories, communities can maximize their readiness if they

- ✎ Contact the SSA or SSA substate office to procure equipment, communication devices, and other disaster-related resources available from local, State, and Federal agencies such as DoD, Department of Transportation, IBM, Motorola, telephone and electric companies, water companies, grocery stores, and so forth. More information about funding is included in Chapter 5.
- ✎ Develop mutual aid agreements among other community organizations, agencies, businesses, and human service programs, especially regarding data system backup and storage arrangements. Agreements regarding emergency assistance may also cover staffing, client sheltering, medical care, meals, and other related goods and services. Further details, especially about working with volunteers, are included in Chapter 4.

The work undertaken in this preparedness phase may seem arduous. However, as is made clear by comparing the two case studies, it will pay off when a disaster occurs. Working together and in parallel before disaster occurs, State/Territory and community substance abuse agencies and organizations can maximize the effectiveness of postdisaster substance abuse prevention efforts.

3. Disaster Response—
Providing Remedial Assistance

This chapter on the disaster response phase is brief—not because it is unimportant—but because rather than substance abuse workers, the primary players during this phase will be those professionals trained to perform in urgent and dangerous circumstances, such as rescue squads and other medical personnel, fire fighters, security patrols, and communications experts. It should be noted that any action that minimizes the physical destruction, loss of life, or human injury also reduces the potential for substance abuse problems in the aftermath of the disaster. It is the unrelenting emotional stress resulting from these losses that can give rise to increased substance abuse. Substance abuse service providers who are in a position to build a flood dike or operate a switchboard should see these activities as the most effective means available of preventing substance abuse during this phase.

Goals and Objectives for Disaster Response

Very often, the distinction blurs between the activities and responsibilities of State authority workers and community organization workers in the response phase, as people try to bring basic services to the scene of the disaster. The common goal shared by State/Territory substance abuse authorities and community organizations during the response phase is to facilitate and coordinate their own substance abuse response efforts with all other disaster response efforts. During the response phase, this may mean supporting activities that, on the surface, appear to be outside the realm of substance abuse prevention.

For example, as mentioned in Chapter 1, substance abuse and mental health workers who sought to work in their field of expertise during Hurricane Andrew instead helped survivors find food and water, directed people to economic assistance, and even moved fallen trees and other barriers limiting access to disaster areas. Once basic survival needs were handled (within 10 days to 2 weeks), higher level emotional needs surfaced, which in some cases included the need for substance abuse and mental health services.

Strategies and Action Steps for Disaster Response

In the response phase, substance abuse prevention activity should be guided by the general principle that anything that helps meet basic needs, aids in coping with stress, or speeds return to normal life after a disaster is likely to prevent alcohol, tobacco, and drug problems. Substance abuse workers should therefore allow for emergency relief workers to

do their jobs. If the substance abuse workers wish, they may offer some assistance, but otherwise they should yield to those who are trained in emergency relief procedures.

Strategies and Action Steps for State/Territory Disaster Response

The ways in which the State/Territory substance abuse system can assist a community will vary according to the size and severity of the disaster, the geographic region, and resources available. Specific recommendations to include in response strategies by State/Territory substance abuse authorities are listed below.

- ✎ Recruit disaster relief workers who are indigenous to the disaster area or who are aware of the characteristics of the affected population. Include members from affiliated communities on the disaster teams providing outreach. Bilingual paid workers or volunteers are often needed and can be ready and available in the initial disaster relief efforts.
- ✎ Be involved with substance abuse and mental health leaders in the preliminary State/Territory damage assessment process to ensure that substance abuse and mental health needs are factored into the subsequent response and recovery efforts.
- ✎ Immediately begin the disaster assistance application process using the prearranged grant application developed in earlier disaster preparedness efforts. Communication disruptions may reduce the information available about the disaster's impact, and best estimates may have to be used initially.
- ✎ Make immediate efforts to help the community substance abuse system stay informed about relief and recovery efforts.
- ✎ Conduct rapid technical needs assessments of the communication system (phone, fax, etc.) at the time of the emergency and during the immediate aftermath.

Strategies and Action Steps for Community Disaster Response

While some community-level volunteers and caregivers impacted by a disaster may be in a position to assist the State and Federal effort, many more may have been impacted by the disaster themselves and initially will need to rely on help from others. Therefore specific steps for community organizations are not offered here. Community workers who are able and wish to help should find ways to support the Federal and State/Territorial efforts under way. Other community workers should understand that they will be most helpful to others during the later recovery phase if they have taken care of their own needs during the immediate response phase.

Resource Utilization for Disaster Response

During the disaster response phase, States/Territories and community organizations, working together, should activate existing plans for resource allocation. If no substance abuse plans have been made, note the information in Chapter 2, "Disaster Preparedness." In addition, other States and communities might be asked for assistance.

4. Disaster Recovery—
Returning Systems to Normal

The discussions of the earlier phases of disaster began with sections on "Goals and Objectives." This chapter begins with a discussion of the survivors of disasters because the recovery phase offers the first real opportunity for substance abuse workers to provide needed services to disaster survivors.

The recovery phase begins after basic needs are met, when efforts turn toward the process of bringing life back to normal. The focus on logistical concerns switches at this point to the emotional turmoil left in the wake of a disaster. Early in the recovery phase, substance abuse preventionists can fulfill their role by supporting efforts that focus on human emotional concerns. Helping disaster survivors to reestablish normal life as soon as possible and, later in the recovery phase, providing further opportunities to share community activities can prevent substance abuse. Helping survivors requires an understanding of how disaster creates emotional stress and places individuals at increased risk for substance abuse.

Understanding Survivors

Major disasters completely disrupt the normal living patterns of a family and a community. Survivors may find themselves without food, water, or clothing, separated from family and friends, and stripped of their ability to communicate with the outside world. They may need to share shelter space with relatives, friends, or strangers. Some may feel the need to stay in the shell of their own destroyed home to protect their few remaining possessions from looters. Disaster survivors may find that they have lost everything, including personal possessions representing links with the past that cannot be replaced (e.g., family photographs, letters).

People vary greatly in their ability to recognize their own needs and in asking for help. There are also cultural differences in help-seeking behavior. Some feel that it is personally degrading or embarrassing to request clothing and bedding or to seek an emergency loan. In a large-scale disaster, very often the helpers are survivors themselves and must not only deal with their own losses but help others as well.

The following sections are provided to help community agency staff respond most effectively to the needs of disaster survivors during the recovery period (1 week to 3 months in the short term and up to 2 years in the long term). Included here is basic information about characteristics of survivors, the phases that survivors go through in response

to a disaster, symptoms and behaviors that signal stress, age-related issues, and urban/rural differences. Subsequent sections of this chapter deal with the goals, strategies and action steps, and resources that pertain to the recovery phase.

Characteristics of Disaster Survivors

Most Are Emotionally Stable People

Survivors of a disaster are generally emotionally stable people who are experiencing extreme stress and anxiety and who exhibit their reactions in different, sometimes bizarre, ways. These transitory symptoms are normal responses and do not imply serious or persistent mental or emotional illness. An example may be seen in a man whose home was completely destroyed in the 1993 Midwest floods. He had dragged his water-soaked furniture and clothing into the front yard and was found folding and refolding his clothes in small piles. After his neighbors spoke to him and gave him some food, he recovered his composure and was able to help with the larger, more immediate activities.

They Do Not Disintegrate in Response to a Crisis

In most cases, people do extraordinarily well in response to a disaster, especially in the initial phases. Many stories of extreme heroism and selfless acts accompany disaster events. Frequently people need to be forced to rest, take care of themselves, or take a few days off from the relief efforts.

Most Respond to Concerned Interest and Helpfulness

Survivors will follow the lead of those who are being genuinely, tangibly helpful. Even if the help is holding a baby for a moment, bringing some water to a disaster application line, or helping to move debris, people tend to respond positively to human involvement. In general, preventionists or other helpers who demonstrate positive concern tend to elicit positive responses.

Intervention Principles for Service Providers

The preceding characteristics of survivors, then, dictate that the following "principles of intervention" be observed by service providers:

- ✎ Recognize that disaster survivors are generally normal people under severe stress, and help them, if necessary, to recognize their behavior as a temporary dysfunction.
- ✎ Focus on the strengths and coping skills of the survivors and on problem solving.
- ✎ Allow families and communities with shared experience to serve as a primary source of support and healing.
- ✎ Allow survivors to use natural support systems (such as family, peers, etc.) if available.
- ✎ Treat children and elders as special target groups in need of attention.
- ✎ Refer survivors needing substance abuse and other mental health services to regular programs.

- ✎ Consider the cultural context, the community experience, and the familiarity with mainstream culture of the families and individuals being served.
- ✎ Be sensitive to language fluency in individuals and families and use translators, including volunteers who can translate.
- ✎ Be action-oriented advocates for individuals and families.
- ✎ Empower survivors through education, information, understanding, and skills.
- ✎ Provide assistance or crisis intervention that is time limited and problem focused when the number of persons needing assistance is great.

Common Phases of Disaster Response Experienced by Survivors

Survivors and helpers involved in disaster relief and recovery activities have provided a particularly useful way of describing the experiences of disaster survivors.

Figure 1 illustrates the phases of sometimes overlapping human emotions and reactions that a disaster can precipitate. The information may be helpful in planning effective disaster-related substance abuse interventions.

Alert Phase

The alert phase can occur as people become aware that they could be affected by a destructive event and coincides with governmental warning and evacuation notices. A person's response to the alert phase will vary tremendously based on that individual's personality, past experiences, perceptions of actual danger, and the implications of the event to self and significant others. However, depending on the type of event, e.g., earthquake, there may be no time for an alert phase.

Heroic Phase

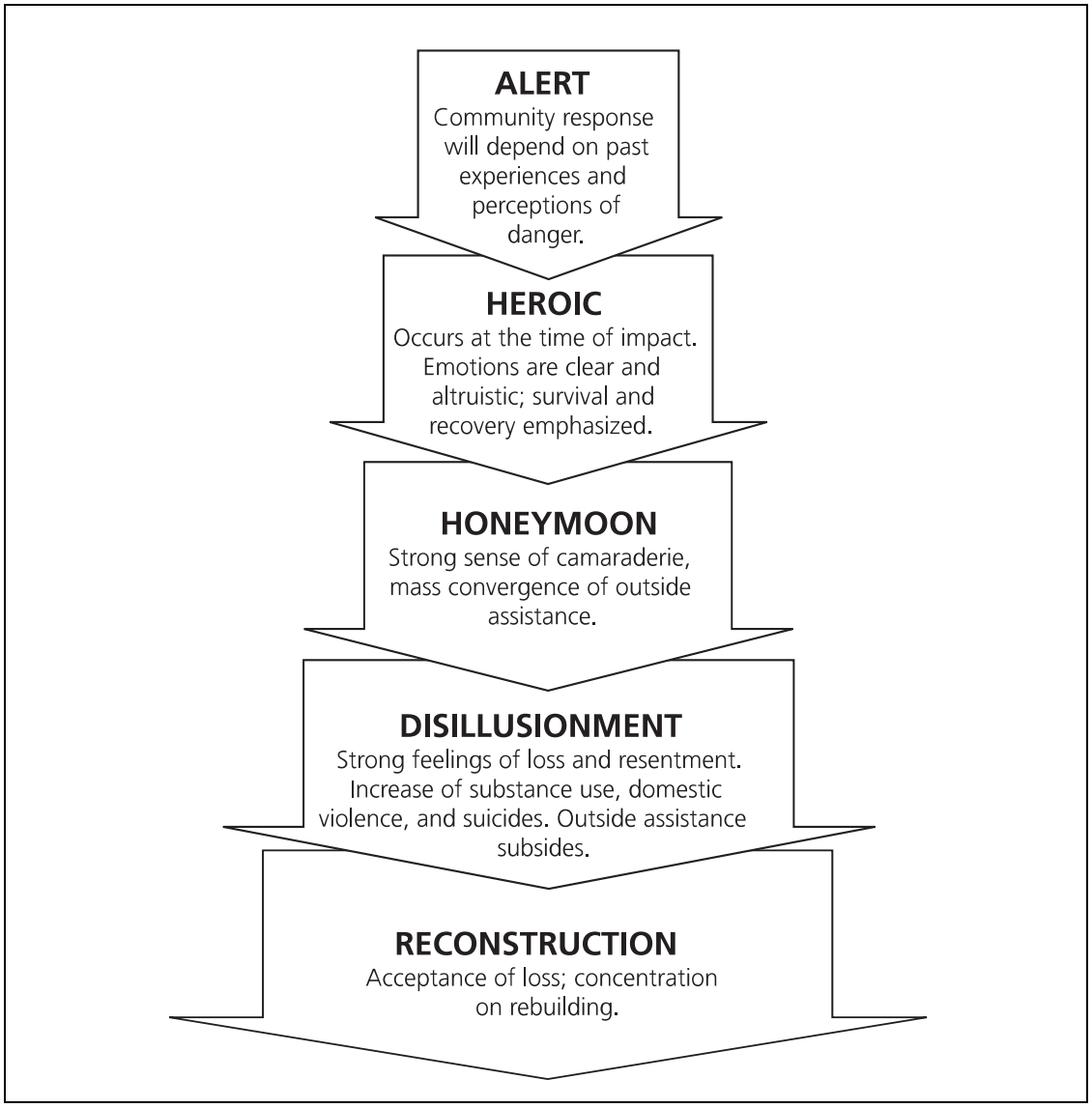
This phase usually occurs during disaster impact and immediately following. Family groups, neighborhoods, community groups, and emergency teams expend much energy in helping others. Emotions are generally clear, direct, and altruistic. Intense effort is put forth toward survival and recovery.

Honeymoon Phase

The honeymoon phase may last from 1 week to 6 months following a disaster. It is characterized by a strong sense of camaraderie among people who have survived a dangerous and devastating event together. As the recovery effort begins, people band together, sharing all kinds of activities, from cleaning and rebuilding to working through the grief process for homes, possessions, and lost loved ones. Generally a large influx of volunteers, government entities, elected officials, and others pours into the disaster zone to assess the damage and cleanup needs, help in recovery efforts, and promise support to the survivors.

For example, in June 1994, a flood destroyed much of the city of Albany, Georgia, and surrounding areas. Within 2 weeks after the disaster, the city had begun in earnest the process of organizing, planning, cooperating, and rebuilding. Coalitions of citizens from all socioeconomic levels and different cultural and ethnic backgrounds, Federal agencies, State and local government agencies, businesses, and other private sector organizations joined together to secure their neighborhoods, schools, and communities.

Figure 1. Five Phases of a Disaster That Influence Behavior



Disillusionment Phase

This phase—characterized by strong feelings of anger, loss, resentment, and bitterness—can last from 2 months to 2 years. Hopelessness and depression may surface as expected support does not materialize. Negative feelings are reinforced as delays occur in rebuilding; as outside agencies and volunteers pull out; as individuals begin to focus on their personal needs and problems; and as community groups begin to lose their common goals. It is during this phase that people may be most vulnerable to ineffective coping behavior and stress-related disorders such as substance abuse, domestic violence, and thoughts of suicide.

Reconstruction Phase

This final phase, possibly lasting several years, may be seen as the goal for disaster relief and recovery. During this time, survivors determine that the business of recovery is

their responsibility and are able to accept this with less bitterness. As survivors concentrate on rebuilding and strengthening their families, homes, businesses, and communities, they feel a renewed belief in themselves and in their capabilities. As in any crisis situation, people strive to return to their precrisis level of functioning, if not to a higher level of functioning gained from their newly acquired strengths. This phase does not occur for some individuals who may develop serious and chronic emotional or behavioral disorders.

Symptoms and Behaviors That Signal Stress

Watch for and recognize stress symptoms in disaster survivors that can be expected in the aftermath of a disaster. Although these symptoms constitute normal responses to the extraordinary circumstances, they should not be ignored or neglected. Symptoms may not be present until after the honeymoon phase described above. Common stress symptoms include

- ✎ Extreme fatigue or inability to sleep;
- ✎ Low resistance to illness;
- ✎ Feelings of fear and anxiety;
- ✎ Emotional numbness, resignation, and the appearance of not caring;
- ✎ Memory and concentration problems;
- ✎ Short temper and irritability, lowered threshold of tolerance for certain kinds of behavior;
- ✎ Feelings of helplessness, loss of hope, and depression; and
- ✎ Frequent crying spells owing to grief and loss.

Some survivors are able to return more quickly to normal activities than others. A very small percentage will be able to continue to function showing no signs at all of undue stress. Also, disaster losses and the ensuing emotional responses may be felt differently by people who have

- ✎ Inadequate insurance coverage,
- ✎ Precarious job situations and minimal job opportunities and skills,
- ✎ Little knowledge about available help, and
- ✎ Little confidence in government or others outside their own family to provide help.

In addition, people who were at high risk prior to the disaster may be pushed beyond their limit afterward. The risk that some people might go into a deep depression and become suicidal should not be underestimated. The need for a support system in such cases can be especially important.

Some other points to keep in mind are

- ✎ People are not inclined to identify themselves as being in need of counseling or preventive mental health services. In addition, they may be unaware of the nature and seriousness of their symptoms. There may be cultural barriers to seeking help or identifying need outside the family or culture group.
- ✎ In disasters that have a recurring character (e.g., repeated flooding, earthquakes followed by major aftershocks), the healing process may be put on hold and the tendency for relapses can be exacerbated.

Children and youth, the frail elderly, and people with preexisting mental illness are at high risk. The following sections expand on the special needs of these groups.

Age-Related Issues

In working with different age groups, the keys to success will be respect, interest, knowledge, flexibility, readiness to learn, sensitivity, and understanding.

Children and Youth

To understand children and their emotional responses to a disaster, it is important to understand the factors that influence a child's response. It also is important to remember that different cultures may define and organize families differently. The mainstream concept of nuclear family is often inadequate for other cultural groups, which may define "family" in much broader terms. In addition, an adult's reaction to other family members who are missing, injured, or dead may have a considerable impact on children in the family.

Major factors that may play a role in the child's response to a disaster include

- ✎ The child's developmental age (which continues to affect their responses before and after a disaster);
- ✎ The child's perception of the responses of adult family members, especially parents (children can be especially sensitive to their feelings and actions in the aftermath of a disaster); and
- ✎ The amount of direct exposure the child has had to the most destructive aspects of the disaster.

Other factors affecting children's responses to disasters include

- ✎ Past functioning (existing conditions or behaviors prior to the disaster),
- ✎ Past experience with other natural or declared disasters,
- ✎ Social/political conditions in original environments of some families,
- ✎ Family economic status,
- ✎ Prior trauma/loss,
- ✎ Losses involved in current event,
- ✎ General disruption in the aftermath of a disaster,
- ✎ Available support and resources, and
- ✎ Concern over family pets.

For more insight into how children respond to disasters, it is useful to categorize the reactions by age. There are distinct differences in children's developmental stages that generally correlate with their emotional responses to catastrophes. These are summarized in Table 3. It should be emphasized that these signs are part of the normal disaster response and may be present for days, weeks, and even months after the disaster. It is important for parental figures to recognize if any of these signs persist. If so, the aid and advice of a mental health professional should be obtained.

Table 3. Age-Related Reactions of Children to Disasters

Age Group	Behavior
Preschool (0–5)	Crying: whimpering, screaming, explicit cries for help Immobility: with trembling and frightened expressions Running: either toward the adult or aimless motion Regressive behavior: thumbsucking, bedwetting, excessive clinging and whining, loss of bowel/bladder control, fear of darkness, fear of animals, fear of being left alone or of crowds or strangers, asking to be dressed or fed Sleep anxiety: nightmares, night terrors, inability to sleep without light or unless someone is present, inability to sleep through the night Marked sensitivity to loud noises Weather fears: lightning, rain, high winds Sadness: especially over persons or prized possessions Speech difficulties Eating problems: loss of or increase in appetite, change in diet
School Age or Pre-adolescence (6–11)	Regressive behavior: similar to preschool, however, marked in degree Sleep anxiety: nightmares, night terrors, unwillingness to fall asleep, need for night light (fear of darkness), fear of sleeping alone, interrupted sleep Weather fears: lightning, rain, high winds Irrational fears: safety of buildings, fear of lights in sky Disobedience Physical complaints (psychosomatic): headaches, stomachaches, nausea, visual or hearing problems Sadness: especially over persons or prized possessions and pets School problems: refusal to go to school, behavior problems in school, poor performance, fighting, withdrawal of interest, loss of ability to concentrate, distractibility Peer problems: withdrawal from play groups, friends, previously enjoyed activities, refusal to go to playground or parties Aggressive behavior: frequent fights with siblings or friends
Adolescence (12–17)	Withdrawal and isolation Physical complaints (psychosomatic): headaches, stomachaches Depression and sadness Suicidal ideation Antisocial behavior: stealing, aggressive behavior, acting out School problems: avoidance, disruptive behavior, academic failures Sleep disturbances: sleeplessness, night terrors, withdrawal into heavy sleep Introduction to or increase in alcohol, tobacco, or drug use Fear concerning loss of family and peers Fears related to their own bodies and their intactness Disruption in peer relationship and social life Fear of losing independence

Helping a child to work through the emotional responses to disaster in a healthy way decreases the likelihood that she/he will turn to alcohol, tobacco, or drugs as a means of coping. Parents, teachers, and other professionals providing disaster-related mental health care should respond to children's emotions/reactions consistently. All caregivers should discuss the event openly and honestly with the child and provide support for, and reinforcement of, the ways in which the child has responded well to the emergency.

In the aftermath of Hurricane Andrew, 10,000 teddy bears were distributed to the children in south Florida. These gifts were particularly comforting to children and especially appreciated by their parents.

Caregivers should provide understanding for the child and offer age- and culture-appropriate information. Specific approaches are offered in Table 4.

Elders

The changing metabolism that accompanies the aging process can make older people more susceptible to the effects of alcohol, illicit drugs, and prescription and over-the-counter medications. Additionally, alcohol use compounds the impact of over-the-counter and prescription drugs and can cause potentially dangerous side effects when mixed with these medications.

Table 4. Approaches Used With Children and Youth To Minimize Negative Responses

	Approach	Description
1.	Acknowledgment of Event	Realistically acknowledging the event with the child while remaining alert to unusual signs of distress, fears, and anxiety in the child.
2.	Reassurance and Comfort	Listening to the child's individual concerns and being especially supportive and comforting.
3.	Tolerance	Being more tolerant than would typically be the case with "acting out" behavior. Be assured that during these crises, one is not indulging or spoiling the child by responding to his/her needs.
4.	Routine	Reinstituting, as soon as it is feasible, a daytime and bedtime routine that may help assure the child that his/her life is secure.
5.	Opportunities to Talk/Play/Draw	Providing ample opportunities for children to express their feelings. Share their anxieties and concerns, providing as supportive an environmental as possible. There can be benefit for a family to remain together as much as possible throughout the emergency (and afterward).
6.	Comforting Bedtime	Reassurance and comfort especially at night can help ease a child's fears.
7.	Family Disaster Plan	Additional information about steps families can take in preparing for and responding to a disaster is available through the local and national Red Cross as well as the Federal Emergency Management Agency.

Age-related stresses—such as loss of loved ones, employment, home, and independence—may put elders at increased substance abuse risk even in normal times. The stress brought on by a disaster can further contribute to this risk. An important issue concerning the elderly, particularly during disaster, is the despair accompanying loss of property and objects. The loss of property and objects may be viewed as a loss of ties with the past or, in the case of newly retired persons, represents the loss of a lifetime of preparation. Additional anxiety can be expected concerning potential losses during disaster recurrences (earthquake aftershocks, recurring flooding, etc.).

In some cultures (e.g., Asian and African cultures), elders will be viewed as the most respected and knowledgeable members of the family and the community. They can be vital sources of stability and reassurance to their communities. They also may serve as community mobilizing agents and volunteer leaders. Often family members will wait until the family elder has been acknowledged and consulted before acting. The loss or injury of the most respected elder during a disaster may be an additional element of psychological disorganization for a family or community.

Preventionists can educate elders about strategies to prevent substance abuse-related problems including misuse of over-the-counter and prescription medications and the dangers of using alcohol in combination with medications. This information is helpful to the elderly during nonemergency times and can be applied to address the added substance abuse risks and stress following a disaster. This information can be provided through workshops and training sessions offered in nursing homes, hospitals, elder care institutions, community centers, and assisted living facilities. The effectiveness of this educational effort may be increased by using an elder trained as a preventionist.

Postdisaster approaches that may be helpful for assisting the elderly include

- ✎ Providing human contact and comfort;
- ✎ Providing strong and persistent verbal reassurance;
- ✎ Assisting with recovery of physical possessions;
- ✎ Making frequent home visits or arranging for companions;
- ✎ Providing for regular contact by phone;
- ✎ Giving special attention to suitable residential relocation, e.g., familiar surroundings and acquaintances;
- ✎ Helping in reestablishing familiar social contacts;
- ✎ Encouraging participation in support group activities;
- ✎ Encouraging self-help and, to the extent possible, involvement in helping others;
- ✎ Assisting in obtaining financial assistance;
- ✎ Assisting in obtaining medical assistance so that medication regime can be reestablished;
- ✎ Discouraging self-medication, drinking to excess, or use of illicit substances; and
- ✎ Providing escort and transportation services.

Geographic Issues

Rural and Urban Considerations

A key difference between rural and urban areas is the concept of community. In a rural setting, community takes on a very different meaning. The social structure of a rural area might be better described as a loose-knit network of nuclear and extended families. Some argue that the focus of prevention efforts in rural areas after a disaster needs to be on families, not communities.

It is a popular belief that the values and the ways of confronting challenges, dealing with problems, and coping with life typically found in rural areas of America are essentially the same as those values, capacities, and skills needed for postdisaster recovery efforts to succeed. However, there are instances where the challenges of rural life can become so profoundly difficult in the aftermath of a disaster that, even with these skills, rural inhabitants may find it difficult to rise to the challenges. For example, in the aftermath of the Midwest floods, U.S. Department of Agriculture regulations required the plowing under of crops for farmers to be eligible for certain funding. For many farm families whose crops were still standing after the flooding, the decision to destroy what they had worked so hard to accomplish so that they might survive financially created severe stress. Again, as a general rule for both rural and urban settings, people organizing postdisaster outreach efforts should recruit volunteers from among traditional, informal community caregivers or from those caregivers and service providers who are most familiar with the backgrounds and lifestyles of those being served.

Gender Issues

In many cases, females assume the role of head of household in the aftermath of a disaster, creating extra stress. They often make arrangements for temporary housing, take care of the basic needs of the family, get through the process of making Federal applications for assistance, and negotiate insurance settlements. In addition, women are far more apt to retain their jobs (or to find new, low-paying jobs) than are men. This can erode the self-esteem of males, especially those who previously had considered themselves to be the primary, if not the sole, breadwinners for the family.

Summary of Survivor Issues

The disaster recovery phase may last up to several years. During this time, survivors determine that the business of recovery is their responsibility, and they begin to overcome the depression that is natural in time of disaster and to accept responsibility without bitterness. As survivors concentrate on rebuilding their families, homes, businesses, and communities, they feel a strengthened belief in themselves and their capabilities. As in any crisis situation, different people respond in different ways in any one moment. Some people strive to return to their precrisis level of functioning or to a higher level of functioning resulting from newly acquired strengths. Some individuals may become ill, or develop serious substance abuse, emotional, or other behavioral symptoms.

While preventionists often expect to do work specifically focused on preventing substance abuse in the immediate aftermath of a disaster, they find instead that more basic human physical and emotional needs must be met. The fact is, meeting these needs is a

very real form of substance abuse prevention. Furthermore, skills that have been historically applied in the field of prevention can be applied in working effectively with disaster survivors:

- ✎ Involving staff and volunteers who are members of the different cultural/ethnic groups being served;
- ✎ Bringing support and needed assistance to where the survivors are;
- ✎ Promoting and reinforcing community partnerships and organizations that support disaster relief efforts because predisaster community relationships and strengths affect the ability to recover;
- ✎ Maximizing substance abuse prevention benefits by providing elder care, daycare for children, and respite for parents and relief workers;
- ✎ Understanding the effect of multiple losses experienced by survivors and the relationship this has to the potential for increased alcohol, tobacco, and drug use;
- ✎ Understanding the devastating effect disasters have on individuals and communities and the potential increase of substance abuse.

This focus on the needs of survivors should be considered throughout the following sections, which address recovery goals, objectives, and strategies and action steps. In any discussion of governmental and organizational roles and responsibilities, it is easy to lose sight of the human element. But, in the context of disaster, it is crucial that this human focus remain clear and constant.

Goals and Objectives for Disaster Recovery

In the previous chapter on disaster response efforts, it was shown that the distinction blurs between the activities and responsibilities of State authority workers and community organization workers, as people try to bring basic services to the scene of a disaster. It is recommended that community workers who are able to help find ways to support the efforts being carried out by State/Territorial or Federal agencies. During the recovery phase of managing a disaster, the goals and objectives for States/Territories and community organizations become more distinct as communities take on increasing responsibility for their own rehabilitation. The goal for State/Territorial authorities, then, is to relinquish their lead role and to take on a supportive position. The goal for community organization efforts in substance abuse-related disaster recovery is to use SSA support to foster community efforts to restore and renew substance abuse prevention and treatment services.

Strategies and Action Steps for Disaster Recovery

Strategies and Action Steps for State/Territory Disaster Recovery

While the substance abuse disaster response phase engages State substance abuse authorities primarily, the recovery phase largely involves community-level activities. General strategies and action steps to be taken by both State/Territory authorities and community organizations focus on outreach work, which extends into the recovery phase.

Recommendations include

- ✎ Resolve people's reluctance to accept or ask for help by providing personal contact with a skilled preventionist, relief worker, or other helper who has the correct information. Be aware that some circumstances call for personal and emotional support, while other situations require more physical and/or financial assistance or referral.
- ✎ Increase outreach services following a disaster; it may not be realistic to require victims to report to an office for services.
- ✎ Match traditional substance abuse preventionists with other mental health professionals who are more comfortable out of their usual office environment to work with disaster relief workers on outreach.

Outreach steps can also include encouraging survivors to use outreach services; making sure that outreach workers have accurate information; and establishing new outreach locations.

Outreach and referral activities are familiar to substance abuse, mental health, and social service providers. In a disaster, these activities become of highest priority. As described in the previous section on understanding survivors, a major challenge confronting outreach workers and service providers is how to identify and reach those needing treatment, counseling, or other supportive services. Several ways to reach survivors are discussed below.

Use coalition-building and coalition-sponsored events as opportunities to develop a support system for those in need. For instance, social or recreational community or small group events can serve several purposes. Outreach workers and service providers can connect with people most obviously in need, to encourage them to use available services and informally share information about these resources.

Other community programs and coalitions have found that advertising themselves as focused on drug abuse prevention or on providing or referring people to mental health services is counterproductive as it tends to "put off" those who may be most in need. Some coalitions that pair their focus on prevention with health promotion or healthy development of the community have found that these orientations give them easier access to the populations they are trying to reach.

One SAMHSA/CSAP Community Partnership program has been extremely valuable to Midwest flood victims. This program is set up ostensibly as a career development center, but also serves as a mental health and social services referral source. In addition, the program provides workshops and counseling on developing coping skills, reducing stress, and dealing with parenting, family, and financial problems. It serves a valuable function by helping people manage their most immediate and pressing problems.

Another example of effective outreach efforts in a disaster aftermath is the Rapid City, South Dakota, flood in 1972. A corps of 135 food and beverage servers and hairdressers were trained as listeners to facilitate community outreach in a situation where professional caregivers were in short supply.

In another approach, first used by the Red Cross, providers of shelter services after a disaster were trained to walk through shelters and listen. When Red Cross workers encountered people obviously in need of help, they would signal others who were more skilled in actually connecting such persons with the mental health services they needed. These services might be provided one-to-one or in small support groups.

Organizations involved in disasters should provide bilingual and bicultural staff volunteers in all phases of disaster services because all cultural groups can differ in identifying and communicating needs. Language diversity and lack of familiarity with mainstream American institutions may be barriers to seeking help. Outreach workers can use existing cultural centers for programs. All staff should be trained to provide essential services in as culturally sensitive a manner as possible. Followup mechanisms should be created to emphasize the option of receiving care from individuals who speak the same language and understand the corresponding cultural norms of the recipients.

During disaster recovery, State/Territory and Federal officials should initiate and maintain regular contact with community organizations so that they can continue to provide guidance and support in renewing community substance abuse prevention and treatment services.

Federal- and State-level authorities will begin to turn responsibility over to the communities. It is important, however, that this transition not be perceived as a "pull-out" on the part of the Federal and State/Territorial governments. Communities will continue to work with the State in rebuilding and recovery efforts. But the communities will have primary responsibility for implementing recovery plans. Therefore, the discussion of strategies and action steps for the recovery phase focuses primarily on the community's role.

Strategies and Action Steps for Community Disaster Recovery

The hands-on work of implementing the disaster strategies developed and making use of available resources goes into full swing during the recovery phase. Therefore, the practical concerns listed below must be addressed by community organizations.

- ✎ Educate and facilitate support for their audiences, through activities such as workshops and seminars, and incorporate disaster-related substance abuse prevention issues in educational curricula and worksite programs.
- ✎ Activate plans to respond to disaster-related substance abuse that are coordinated with those of other local organizations and reflect an understanding of disaster behavior phases and possible substance abuse vulnerability at each phase.
- ✎ Locate and make facilities and vehicles available for disaster aid; organizations should consider whether they will make sites and transportation available and develop policies and training to support these decisions.
- ✎ Identify adults, children, elderly, families, and individuals from demographic groups at risk and provide referrals to appropriate agencies; expand support beyond the specific organization or group to reach individuals at risk who otherwise would be unidentified and unserved.
- ✎ Promote alternatives to alcohol, tobacco, and drug use, such as organized cleanup activities and other suitable volunteer work, recreational and sporting events, and comfort activities such as inspirational/reading discussions and meditation classes.
- ✎ Reduce the stigma attached to substance abuse and other mental health services by providing these services in the context of alternate and/or umbrella programs.
- ✎ Distribute information about disaster-related substance abuse prevention and share it with other groups and organizations; resource directories and information kits may be developed using information from the National Clearinghouse for Alcohol

and Drug Information (NCADI) and local, State, and Federal disaster relief agencies.

- ✎ Take steps to avoid staff and volunteer burnout. (For more information, see the section below entitled "Avoid Staff Burnout.")

The following sections offer additional recommendations for carrying out the action steps described above.

Inform Survivors of Service Delivery Locations

Substance abuse prevention materials for handing out to survivors should include a list of the locations where disaster-related services might be delivered, including

- ✎ Mass-care shelters/temporary housing
- ✎ Schools, childcare centers
- ✎ Parks and campsites
- ✎ Community centers
- ✎ Senior centers
- ✎ Recreation centers
- ✎ Hospitals and clinics
- ✎ Morgues
- ✎ Homes
- ✎ Command posts
- ✎ Neighborhoods
- ✎ Roadblocks, waiting lines
- ✎ Churches, temples, synagogues, mosques, and other places of worship
- ✎ Disaster assistance centers
- ✎ Public meetings
- ✎ Media
- ✎ Grocery stores, liquor stores, thrift shops

Avoid Staff Burnout

Relief and recovery workers expose themselves to unprecedented personal demands when helping survivors in the aftermath of a disaster. They may themselves be victims of the disaster and may be coping with the combined strains of seeing to their own losses as well as those of the people they are helping. For many workers, the disaster may take precedence over all other personal responsibilities and activities. For some, just the opposite may be true. The potential for overworking and "burning out" is ever present among volunteers as well as paid workers and service providers. No one is totally immune, regardless of skill or professional credentials.

Burnout syndrome is a state of exhaustion, irritability, and fatigue that can gradually or quickly overtake workers and decrease their capacity and effectiveness. The most effective

way to prevent burnout is to anticipate it and identify it when it occurs. Symptoms of burnout identified by the National Institute of Mental Health (1978) include

- ✎ Patterns of thought: mental confusion and slowness, inability to make judgments and decisions, loss of ability to conceptualize alternatives or prioritize tasks, loss of objectivity in evaluating one's own functioning;
- ✎ Psychological symptoms: depression, irritability, anxiety, hyperexcitability, excessive rage reactions;
- ✎ Somatic symptoms: physical exhaustion, loss of energy, gastrointestinal distress, appetite disturbances, hypochondria, sleep disorders, tremors; and
- ✎ Behavioral symptoms: hyperactivity, excessive fatigue, confusion in verbal or written expression.

Symptoms may appear early or well into the postdisaster period, from 2 weeks to a year. They may continue long after that. On average, it takes approximately 4 to 6 weeks for most symptoms to appear. The earlier these symptoms are identified, the better. All personnel need to be instructed about these symptoms so that they may recognize the symptoms in themselves and in others.

When such symptoms begin to appear, the worker should be officially relieved of his or her duties for a short time. Official permission will help relieve any possible guilt over leaving the disaster activities and duties. It is also helpful to point out how burnout not only results in ineffectiveness but also makes the person more susceptible to health problems, including mental health and stress-related problems.

Workers typically burn out because they drive themselves too hard, fail to take care of their own needs for food and rest, become overwhelmed by all they see and do; they may not appreciate their accomplishments or may become overly exhilarated by their sense of accomplishment. Worker frustration levels can be minimized by helping them focus on what has been accomplished and on how much is being done, not on what remains to be done.

Other suggestions include the following:

- ✎ Impress upon workers the need to avoid alcohol and drug misuse, especially for self-medication.
- ✎ Educate supervisors about burnout behavior and culturally sensitive intervention.
- ✎ Encourage those in supervisory roles to take time to nurture workers and to be alert to signs of burnout.
- ✎ Impress upon workers the importance of pacing themselves, and getting adequate rest, relaxation, food, and water (especially in situations where heat-related dehydration is a threat).
- ✎ Encourage the use of humor, when appropriate, to relieve stress.
- ✎ Provide opportunities for debriefing, talking, sharing experiences, and venting feelings one-on-one, in small groups, or in formal support groups with facilitators.
- ✎ Provide opportunities for debriefing in situations involving dead, dying, and severely injured people.

Resource Utilization for Disaster Recovery

Resource Utilization for State/Territory Disaster Recovery

In its supportive role, the State authority acts more as a provider or conduit of recovery resources rather than as a user. State/Territorial substance abuse workers can help their community-level colleagues in applying for funding from Federal agencies, including FEMA, the Center for Mental Health Services (CMHS), SAMHSA/CSAP, and the Center for Substance Abuse Treatment (CSAT). FEMA may provide funding for building new structures or rebuilding structures that have been destroyed in the disaster. SAMHSA/CSAP and CSAT may provide funding for establishing or reestablishing programs for substance abuse prevention or treatment. CMHS provides crisis counseling grants.

Resource Utilization for Community Disaster Recovery

At the community level, volunteers are a primary resource. In most cases, volunteers will be affiliated with one or more community organizations, which themselves may be considered resources. Schools, the faith community, businesses and corporations, and parks and recreation groups can provide culturally sensitive disaster-related substance abuse services and resources that are tailored to their specific audiences (e.g., students, workers, or churchgoers) and that use an array of media, especially media to which the organizations have unique or special access, such as a company's mail or the religion section of the local newspaper. Other media outlets also belong to the list of community resources.

What follows are comments specific to volunteers, schools, the faith community, businesses and corporations, parks and recreational groups, and media channels.

Volunteers

This section discusses a few preliminary considerations in working with volunteers. Useful resources for dealing with these and other issues appear in Chapter 5, "Funding."

Volunteers may focus their efforts in any of a multitude of ways in the context of disaster mitigation and preparedness, response, and recovery efforts. Steps in developing a volunteer response program are discussed in *Ready to Respond: A Disaster Preparedness Manual for Volunteer Centers,* prepared by the Points of Light Foundation. The manual also contains a wealth of information and insight concerning ways organizations and agencies, including businesses and corporations, can be more effective in all aspects of disaster management, from preparedness planning through long-term recovery efforts.

Another approach to the subject of volunteers and disasters focuses on organizational, logistical, administrative, and skill-related and training-related concerns. This approach is discussed in materials developed by the State of Florida, HRS, Emergency Medical Services. Some of the key issues in the early stages of volunteer use in disaster management include

- ✎ Disaster management staff may not anticipate as large a volunteer response as occurs.
- ✎ No system may exist at the time of the disaster to match volunteer skills with the needed skills.

- ✎ It may be difficult for disaster staff in the field to "validate" required credentials or required skill levels to perform certain duties.
- ✎ Volunteers may have unrealistic expectations about how they will operate and be supported at the disaster site.
- ✎ Some professional response groups—fire, emergency medical services, emergency management, etc.—may resent the arrival of volunteers and either refuse to work or have difficulty working with them.
- ✎ The contributions that unorganized volunteers may be able to make to the success of disaster recovery efforts are likely to be extremely limited.

Thorough planning is needed to prepare for and respond to these concerns. For example, volunteers might be encouraged to join organized disaster response teams rather than directly offering their services. In addition, volunteers will need a place to report (a staging area) where information about them can be processed and any special licenses and credentials can be verified. Staging area personnel also will have to match volunteers with places where their skills can be used. This may entail establishing data bases and coordinating disaster staffing needs with public information personnel.

Schools

Teachers and school counselors should be encouraged to talk with children about the disaster. Since schools may be one of the few safe structures for children, they provide a setting in which teachers and school counselors have opportunities to support and aid children in coping with their emotions. Furthermore, parents or other adult family members may themselves be so overwhelmed by the destruction that they are not attuned to the child's feelings or feel unable to help. Children need support to process their thoughts and feelings, or they may initiate alcohol, tobacco, or drug use or increase existing use as a way to numb their pain and attempt to cope with their trauma.

Most schools have some type of crisis management plan. This plan can be expanded to include substance abuse-related disaster management. School settings offer a unique opportunity to involve a broad and diverse group of individuals in a substance abuse disaster preparedness effort, including administrators, teachers, counselors, security personnel, bus drivers, health services, students, school resource officers, and parents.

As part of the plan, substance abuse preventionists can work with schools to educate and train members of these groups to recognize and anticipate disaster-related substance abuse in students and families and to provide appropriate services or referrals.

The Faith Community

Many organizations within the faith community have made major contributions to recovery efforts in disasters. These nationally and regionally organized efforts have included the Mennonite Disaster Service, Salvation Army, Southern Baptist Convention, the Adventist Team Community Services, Ananda Marga Universal Relief Team, Catholic Charities USA, Christian Disaster Response, Church of the Brethren, Friends Disaster Service, Inter-Lutheran Disaster Response, and Society of St. Vincent de Paul, along with organizations representing other major religious groups in the United States.

In the SAMHSA/CSAP document *Faith Communities* (1993), then Acting SAMHSA/CSAP Director Vivian Smith summarizes the role of the faith community as follows:

"Faith and religion play an enormous role in the lives of many individuals. This reality gives leaders of faith communities a unique and wonderful opportunity to reach and help many people in their congregation and neighborhoods. One of the most crucial concerns affecting Americans today, unfortunately, is substance abuse problems."

Faith communities are increasingly recognizing their role in substance abuse prevention by including substance abuse prevention information in their life enrichment and other instructional programs and establishing clear substance abuse policies with expectations for members of the faith community. There are many roles members of the faith community can play that will contribute to preventing substance abuse-related problems brought on by a disaster. In some cultural groups and communities, religious organizations play a central organizing role, bringing together segments of the community—professionals, business leaders, families, etc. These religious organizations can play a lead role in organizing volunteers, communication and outreach, shelter services, counseling, and recovery.

Businesses and Corporations

Smaller businesses and larger corporations may have altruistic motivations as well as vested self-interests in assisting with community efforts. They may already be involved or may wish to be invited to participate in disaster preparedness, response, and recovery for any of these key reasons:

- ✎ Sense of social responsibility;
- ✎ Wish to minimize death, injury, and losses;
- ✎ Protection of employees and operating environment;
- ✎ Concern for employees and customers;
- ✎ Desire to expedite recovery process; and
- ✎ Good public relations.

Their levels of involvement may be influenced by any or all of the following:

- ✎ Impact or likely impact of the disaster on employees and operations;
- ✎ Severity of damage to business or corporation;
- ✎ Severity of damage to the surrounding area;
- ✎ Input and leadership of management, owners, or officers and governing boards;
- ✎ Requests from major disaster-related organizations and agencies;
- ✎ Nature of linkages with disaster-related organizations and agencies, including the role, if any, in disaster planning efforts in the community, county, area, region, or State or Territory;
- ✎ Prior involvement in other disasters, including involvement of employees or employee associations in self-help or communitywide efforts; and
- ✎ Responses by other businesses and corporations.

Business Cooperation with Community Groups

Community organizations and coalitions might encourage industries and companies to provide flexible working hours and working arrangements. In the 1994 Los Angeles earthquake aftermath, there was a marked increase in home/office telecommuting, which allowed individuals to work at home on personal computers tied to office computers via phone lines. However, for telecommuting to be successful, the necessary hardware and software must be set up, and administrative procedures should be in place before a disaster strikes.

If businesses and corporations must scale back employment because of a disaster, community organizations and coalitions can encourage businesses and corporations to provide outplacement services, sponsor job fairs, or promote a wide range of options, including support groups and "drop-in" work centers where people can go to work or get further employment references. These activities might also become sites for substance abuse prevention activities.

Employee Assistance Programs

Employee Assistance Programs (EAPs) address a wide range of problems, including emotional problems, marital and family discord, financial or legal difficulties, health problems, and substance abuse-related problems and serve as resources that employees and their families can turn to for confidential and professional assistance. EAPs may conduct confidential assessments and provide short-term counseling or refer employees to appropriate therapists or treatment programs in the aftermath of a disaster.

Parks and Recreation

Parks and recreational settings provide an ideal location for trauma-related substance abuse prevention efforts for children and families after a disaster. They can become an oasis for children and families who have been negatively impacted by a disaster. Additionally, park and recreation workers and volunteers can be trained by preventionists to identify people at risk, to make referrals, and to assist children and families in obtaining needed diversions from the disaster.

Media and Information System Providers

The following discussion provides (1) examples of the effective use of some available media and technology and (2) a description of some relevant SAMHSA/CSAP services.

In general, dealing with the media should be part of predisaster planning to ensure that correct information is aired and that all communication is coordinated. Cultural and foreign language-based outlets should be considered for use in disaster preparedness, response, and recovery.

Radio and Television

In the wake of the 1992 Los Angeles civil disorder, members of the South-Central Organizing Committee, a CSAP Community Partnership, saw an opportunity to block the reauthorization of burned-out liquor stores. Their efforts brought media coverage to activities such as a block party designed to present coalition issues to the neighborhood. They also used radio talk shows to their advantage. If broadcasters did not cover community

meetings, the coalition wrote its own releases and called the stations. The coalition recruited callers to volunteer their opinions on the radio talk shows.

In other postdisaster situations, call-in radio and TV shows can give mental health and substance abuse specialists a forum for fielding questions and providing advice, information, and referrals. In addition, these shows can be used to provide up-to-date, accurate information and to defuse potential postdisaster crises. These shows also can educate the public about the potential for increased alcohol and drug use in the aftermath of the disaster.

PSAs also can be used in this educational strategy. For example, the California Department of Alcohol and Drug Programs suggests that the message, "You've lost your home, your friends, your safety...it's time to keep your wits," accompanied by a hand shoving away a drink, can be used in a brief but effective PSA to heighten general public awareness.

During extended power outages, the use of portable radios and televisions, as well as car-powered radios and televisions, can make prevention-related programming more widely accessible. The use of "hand-cranked radios" that do not rely on electrical outlets or batteries became more widespread in the Los Angeles earthquake.

Amateur Radio Operators

Amateur radio operators, or "hams," have often volunteered their skills and equipment to provide emergency communication channels in a disaster and during the period following it. This communication means has been of great assistance, not only to victims but also to disaster response agencies. There have been times when amateur radio operators provided the only available information source in the immediate wake of a disaster.

Print Media

After the East Bay Hills fire on October 20, 1991, several Oakland United Way agencies served as a focal point for coordinating the efforts of 50 new and preexisting neighborhood groups collectively called the Phoenix Coordination Council. These organizations produced the *Phoenix Journal,* whose primary task was to "help rebuild the East Bay and to maintain communication between the people who lost their homes on October 20, 1991, and among those whose homes survived."

In addition to establishing new publications, preventionists can use established print media such as existing daily newspapers to ensure that accurate information is presented and to help survivors learn about resources. From the preventionist's point of view, established print media may be a relatively inexpensive channel for messages aimed at preventing substance abuse after the initial response phase.

Electronic Media

Depending on the status of the electrical and telephone systems in the area, the following may be part of a communications system: mobile faxes and mobile phones, E-mail and Internet, and individual and community voice mail systems.

PREVline

PREVline ("PREVention online") is a SAMHSA/CSAP computer-based message and information service used to exchange ideas and information within the prevention community. It seeks to promote communication at a personal level by providing a direct link among SAMHSA/CSAP, NCADI, and prevention professionals in the field. Through the establishment of forums focused on a range of subject areas, prevention professionals can congregate electronically to raise questions and share information. Users can correspond with each other toll-free in emergency situations. Special information from SAMHSA/CSAP concerning disaster response can be accessed.

Conclusion

In the aftermath of a disaster, substance abuse preventionists may feel that their primary concern is to reestablish their regular services as quickly as possible so that they can get back to business as usual. Indeed, this goal is important because the emotional stress caused by disaster will inevitably increase the demand for effective prevention messages and programs. The unique circumstances created by the disaster, however, may create additional and more immediate concerns that pull substance abuse service providers into areas that may appear to be outside their realm. At this point, it is important to remember that all services that address mental health issues are potentially substance abuse prevention services, since they address the environmental factors that can give rise to increased alcohol and drug use and other maladaptive behaviors. This chapter has presented a discussion of survivor issues in order to prepare substance abuse service providers to deal with the extraordinary circumstances that a disaster can create in the lives of ordinary people. The discussion of recovery goals, objectives, strategies, action steps, and community resources has been presented to prepare preventionists to contribute to a coordinated and comprehensive community effort. It is important to remember that, in the wake of a disaster, any human service that meets an emotional need can be viewed as an act of prevention.

5. Funding—
Obtaining Funding Assistance

The following information can be used to develop strategies for obtaining funding and other assistance throughout the phases of a disaster, but these strategies should be developed primarily as part of the preparedness phase to maximize their effectiveness. As a first step in developing funding strategies, it is important to learn about government sources of funding assistance. Disaster-related substance abuse prevention funding may not be readily available to State and Territorial or local substance abuse prevention agencies and organizations, as other demands for resources based on more immediate survival needs usually overshadow substance abuse-related disaster funding requests. However, there are some funding sources that should be considered and used where possible.

Although State or Territorial governments have fewer funds than the Federal Government to allocate to communities for disaster relief, they do have a strong public mandate and Federal encouragement to respond to disasters. Their role in disaster management parallels that of the Federal Government, but on a different scale. The State or Territory is responsible for developing and maintaining a comprehensive program of preparedness, response, and recovery activities; for supplementing and facilitating local efforts before, during, and after emergencies; and, when local capabilities fall short of disaster demands, for being prepared to maintain or accelerate services and to provide new services. It is important to note that just as State and Territorial substance abuse authorities devote widely differing amounts of resources to substance abuse prevention, States and Territories devote widely different amounts of resources to disaster management and funding.

This chapter includes information about government funding sources, primarily the Federal Government, which is a key player in this area.

Government Funding Assistance

Pathways for Federal Funding

The Federal Government maintains the largest pool of financial resources for disaster management and can provide specialized technical assistance. The next sections discuss specific Federal funding paths and resources that have been historically most applicable to substance abuse prevention funding.

Federal Funding

There are two established funding paths and additional discretionary paths for disaster-related activities once the President has formally declared that a locality is a disaster area.

The first funding path is activated when FEMA, working through the State or Territory emergency management authority, begins a series of disaster response and recovery activities, including making funds available for mental health services through CMHS, a branch of SAMHSA. The importance of linking with mental health leaders, as described in earlier chapters of this *Guide*, now becomes crucial because these linkages can ensure involvement in the preliminary State/Territory damage assessment process, to ensure that substance abuse and mental health needs are factored into the subsequent response and recovery efforts.

The second established funding path is activated when the Governor of an individual State requests funding from the Public Health Service (PHS) of the U.S. Department of Health and Human Services (DHHS). Staff from SAMHSA, a branch of PHS, will meet with other DHHS staff to develop a recommended package of resources for PHS to submit to Congress for approval. In this case, funds are made available directly to the States for distribution to communities and SAMHSA/CSAP grantees.

Federal resources that may be tapped for financial assistance for disaster-related substance abuse prevention include Crisis Counseling Grants. CMHS administers FEMA funds for crisis counseling through the State and Territorial Offices of Emergency Services. In the past such funding has been given to paraprofessionals in educational and crisis counseling roles, typically under the auspices of mental health clinics. On occasion, for example, during Hurricane Andrew in South Florida, crisis counseling funds have been granted to other community-based centers or organizations, such as Volunteers of America.

Those programs awarded crisis counseling grants through the States must show the following qualifications:

- ✎ Adequate training in crisis counseling,
- ✎ Supervision by a mental health professional, and
- ✎ A well-functioning referral capability.

Two forms of funding exist under the Crisis Counseling Grants: funding for immediate services and funding for regular services. The first covers a 60-day period and the latter covers a 9-month period. Extensions are possible, but justification can be a rigorous process.

The development of funding strategies in the aftermath of a large-scale disaster should take the following into account:

- ✎ Substance abuse problems may not appear until 6 months to a year after the disaster has occurred. In this case, a significant amount of time will have passed, making it difficult to link the apparent symptoms with the disaster and to justify the continuation of disaster-related funding for substance abuse services.
- ✎ Under current disaster legislation, the Federal Government is required to provide disaster funds only to help the State reestablish infrastructures and services damaged in a disaster. While there have been very rare cases where funds were used to

establish a new infrastructure and provide new services, continuation of Federal disaster funding for such needs has become a policy dilemma.

- ✎ State and Territorial agencies should be aware that not all communities under their jurisdiction deem crisis counseling to be a priority in their response and recovery efforts.
- ✎ Although a need for crisis counseling may arise, this need alone may not be deemed sufficient justification for a State to receive disaster-related funding. The State or Territory must demonstrate that it is devoting already-existing resources to addressing the problem to the extent it can.
- ✎ Supplemental Funding for Grantees—Community Partnership Grantees and community drug prevention coalitions that provide counseling in the abnormal situation of a natural disaster may be eligible to apply for funds available through those State mental health officials responsible for disaster response and recovery. Under the provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, States and Territories are required to apply for funding from FEMA first. If they are not eligible to receive FEMA funds, States may then apply for DHHS Supplemental Funds. Although SAMHSA has already recommended to DHHS that this process be streamlined, questions remain about using supplemental funds for disaster-related efforts, including those involving substance abuse prevention.

Additional discretionary funding paths may be established by SAMHSA/CSAP, either directly or in response to a request from PHS. In either instance, SAMHSA/CSAP may be able to divert funds not yet allocated to the States or Territories to support disaster-related programs.

SAMHSA/CSAP has no block grant funding set aside for disaster-related substance abuse prevention. In many States, block grant funding is obligated a year or more in advance. States or agencies with contracts may be able to redirect funds from those contracts, but new funds and expanded contracts are unlikely without SAMHSA/CSAP authorization for additional disaster relief funds that can be added to block grants.

Sample Disaster-Related Substance Abuse Prevention Funding Allocations and Requests

Some examples of services, funding levels, and program rationales that SAMHSA and CSAP provided are summarized in the next few pages.

1996 Update on SAMHSA/CSAP's Allocations for Assistance After the 1993 Floods in the Midwest

Technical assistance was provided for all SAMHSA/CSAP project officers who managed programs in the Midwest. This assistance included enabling the officers to benefit from lessons learned in responding to Hurricane Andrew.

SAMHSA/CSAP developed PSAs in cooperation with major league baseball teams in the flood area. These PSAs encouraged flood victims under extreme stress to seek help and included the State's substance abuse and mental health toll-free telephone numbers.

SAMHSA/CSAP helped provide alternative and recreational activities in cooperation with the U.S. Fish and Wildlife Service (Department of the Interior) and two branches of

the Department of Justice. The Bureau of Justice Assistance provided aid through the National Crime Prevention Council's community service program, and the Office of Juvenile Justice and Delinquency Prevention provided services through the local Boys and Girls Clubs.

Assistance was provided to the States in producing public safety and other prevention messages immediately after the flood.

Training on substance abuse prevention and postdisaster recovery issues was provided to all SAMHSA/CSAP Midwest grantees affected by the flood. Similar training was offered to State directors and park and recreation directors.

Prevention funds were awarded from the Emergency Supplemental Appropriation Act of 1993; these grants were made through cooperative agreements with affected States.

The SAMHSA Supplemental Budget Request Made in Response to the Los Angeles Earthquake

SAMHSA/CSAP, working in conjunction with the State of California and Los Angeles County prevention personnel, was able to provide short-term (up to 1 year) substance abuse prevention activities tailored to the crisis. The goals of this section of the proposed grant were (1) to develop new, expanded, creative prevention services and (2) to serve as a catalyst in bringing together community residents to assist one another in rebuilding efforts. Community group involvement was a priority. The needed prevention services identified in the proposal included

- ✎ Recreational and other alternative activities targeted at youth impacted by the earthquake and at increased risk for substance abuse;
- ✎ Development and expansion of parent support groups to help alleviate parental fears and to address related parenting issues;
- ✎ Support for art therapy and other daycare activities for school-aged children experiencing posttraumatic stress;
- ✎ Assistance for individuals who were criminally victimized in the aftermath of the earthquake;
- ✎ Activities that promote a strong sense of community and neighborhood, especially focused on communities experiencing linguistic isolation; and
- ✎ Enhanced community efforts to mobilize local residents to prevent substance abuse.

SAMHSA/CSAP Supplemental Funding for the Los Angeles Earthquake

Several days after the 1994 Los Angeles earthquake, SAMHSA/CSAP made almost $2 million available to five local Community Partnership grantees. These funds are being used to address substance abuse prevention needs. Activities common to all five grantees include

- ✎ Problem identification and needs assessment;
- ✎ Media activities informing residents about substance abuse risks and related problems, and information on local resources;

- ✎ Training in disaster preparedness and stress prevention related to alcohol, tobacco, and drug use;
- ✎ Community forums and town hall meetings identifying needs and discussing strategies for addressing them;
- ✎ Programs offering alternatives to alcohol, tobacco, and drug use for junior and senior high school students;
- ✎ Prevention education curricula for elementary school students and information for families with preschoolers;
- ✎ Leadership development and skills workshops for adults and youth; and
- ✎ Coordination of earthquake relief and recovery activities with other coalitions, planning bodies, and community organizations.

Strategic Steps for Obtaining Funding Assistance

The following should be considered as strategic steps for approaching Federal agencies for funding. They also can be used to enhance approaches to other funding and resource providers.

Create Linkages

Community substance abuse groups should establish and maintain linkages with mental health providers and other organizations as part of disaster-related preparedness. However, linkages also can be initiated to some degree during the recovery stage but at the cost of delayed response time. Linkages with mental health organizations increase coordination of services and enhance the likelihood that the substance abuse prevention providers will obtain funds. Historically, State and community agencies and organizations with established roles as professional, licensed health and social service providers are better able to access scarce funding. Less than a handful of community prevention organizations have ever qualified for crisis counseling grants; typically, these are awarded to community mental health clinics or centers.

Community substance abuse groups also might specifically consider linkages with other local organizations to create consortia and resource pools, to provide an array of services, and to demonstrate sensitivity to different cultures and population groups with special needs, such as the infirm, elderly, and handicapped, in the community.

Community substance abuse groups should contact the State substance abuse authority for help in procuring surplus Army equipment through DoD.

Draft a Grant Application

Draft a grant application that makes a clear, strong case for Federal funding of post-disaster substance abuse prevention programs. The needs assessment portion should contain as much information as possible about the predisaster levels of alcohol, tobacco, and drug use in the State, Territory, or community. Possible data sources include substance abuse-related arrest, hospitalization, and traffic accident data; amount of revenue generated by alcohol and tobacco sales; and data related to sociocultural problems that frequently accompany substance abuse. The application should include all other standard information about the jurisdiction that is typically required. When community

organizations are applying for funds, the State or Territorial authority can assist the local group in completing and strengthening the application.

Obtain sample formats required from potential sources of funding.

If a draft application was not developed for disaster funding during disaster preparedness planning, an application should be completed as fully as possible. Special attention should be given to the needs assessment portion of the application. Overall standards for the document may not be as stringently applied in a disaster.

Disaster Checklists

This section is composed of two checklists, one for State and Territorial substance abuse prevention authorities and one for community substance abuse prevention organizations. Each checklist is separated into the three disaster phases: preparedness, response, and recovery. Substance abuse prevention agencies and organizations should review their respective checklists before a disaster to ensure that they develop comprehensive disaster-related substance abuse prevention plans and to pinpoint areas of existing or proposed plans that need improvement. After a disaster, substance abuse prevention agencies and organizations should review the response and recovery sections of their respective checklists to ensure that their efforts reach optimal levels of effectiveness. The following checklist is intended to help State and Territorial Single State Authorities (SSAs) and State Prevention Coordinator staff assess their readiness for disasters.

Disaster Checklist for State and Territorial Substance Abuse Prevention Authorities	Yes	No	Needs Work
Preparedness: Lessening the Effects of a Disaster We have a well-developed disaster plan for substance abuse prevention services for the three phases of a disaster: preparedness, response, and recovery.			
Our plan is updated at least annually.			
We have contacted all national governmental organizations involved in disaster services and reviewed their roles as they affect our level.			
We have contacted all national nonprofit organizations involved in disaster services and reviewed their roles as they affect our level.			
We have contacted all State governmental organizations involved in disaster services and reviewed their roles as they affect our level.			
We have contacted all State nonprofit organizations involved in disaster services and reviewed their roles as they affect our level.			
We have involved key stakeholders in the development of our plan.			
Our plan is integrated with the State office designated to coordinate disaster services for the State.			

Disaster Checklist for State and Territorial Substance Abuse Prevention Authorities (Continued)	Yes	No	Needs Work
We have identified and resolved all "turf"/jurisdictional issues with other State organizations involved in disaster services.			
We have determined persons/positions responsible for actions/lines with specific agencies.			
We have determined lines of authority, authorization to act in event of incapacitation of leaders or loss of communication in local/regional offices.			
We have educated other organizations and government leaders about the role of substance abuse prevention in disaster planning and services.			
We have developed baseline data for substance abuse problems in our State and specific substate areas that will be needed for disaster recovery funding.			
We have identified the probable services that will be needed for substance abuse prevention and treatment during all phases of a disaster.			
We have identified all potential sources of disaster-related funding for the State to use in providing substance abuse prevention services.			
We have created relationships with sources of funding, obtained necessary application materials, and drafted applications to the extent possible in preparation for a disaster.			
We have reviewed State policies and procedures for provider grants and contracts and modified them to allow for the provision of substance abuse prevention and treatment services that may be needed during the response and recovery phases.			
We have prenegotiated policies and procedures for units of service and reimbursement rates for substance abuse prevention and treatment services that may be needed during the response and recovery phases.			
We have created procedures and policies for an emergency grant process for unexpected services and alternative providers for substance abuse prevention and treatment.			
We have identified the various roles of substance abuse prevention and treatment staff and volunteers for all phases of a disaster and defined responsibilities and experience levels needed for each role.			
We have informed all local substance abuse prevention and treatment agencies of the details of our disaster plan.			
We have provided training to all substance abuse prevention and treatment staff and volunteers on basic disaster response services, preparation required for disaster work, and prevention and treatment services needed in a disaster.			
We have provided training to other key disaster services staff and volunteers on the role of substance abuse prevention and treatment services during a disaster.			
We have issued guidelines for staff and volunteers about needed medical preparation, e.g., tetanus and other vaccinations, as may be required.			
We have identified bicultural and bilingual staff and volunteers for all cultural and linguistic groups within our State.			

Disaster Checklist for State and Territorial Substance Abuse Prevention Authorities (Continued)	Yes	No	Needs Work
We have identified and obtained equipment and supplies that we will need for our staff and volunteers during a disaster (radios, first aid kits, mobile housing, vehicles, etc.).			
We have contacted the Division of State Programs at the Center for Substance Abuse Treatment for acquisition of equipment and supplies from all Department of Defense facilities that are closing in our State and have the equipment ready to use.			
We have arranged emergency housing resources, cash disbursement, and reimbursement policies and procedures for staff and volunteers.			
We have developed a system for checking the credentials of staff and volunteers and issued all staff and volunteers identification that will be accepted by all disaster relief personnel.			
We have developed a system for notifying and assigning staff and volunteers in the event of a disaster that has multiple forms of communication in the event normal communication channels are disrupted.			
We have developed promising approaches for prevention services, trained providers, and assembled the necessary supplies, equipment, literature, etc.			
We have established protocols for addressing substance users whose supplies are interrupted by a disaster and people who may misuse prescription medications, etc.			
We have developed or obtained public service announcements and educational materials for specific substance abuse prevention and treatment issues during a disaster.			
We have arranged for distribution and use of public service announcements and educational materials in the event of a disaster.			
We have arranged for a statewide informational telephone line to be activated and advertised only in the event of a disaster.			
We have sought legislative authority, where necessary, to adequately conduct disaster response.			
We have created mutual aid agreements statewide among our substance abuse prevention and treatment providers during a disaster.			
We have developed backup systems for all records and provided alternate locations if needed to ensure that information will survive a disaster.			
We have created mutual aid agreements with other States for substance abuse prevention and treatment services during a disaster.			
We hold simulations to test and practice our disaster plans and systems at least once every 6 months.			

Disaster Checklist for State and Territorial Substance Abuse Prevention Authorities (Continued)	Yes	No	Needs Work
Response: Providing Remedial Assistance We have established a headquarters for our substance abuse prevention and treatment services at the central disaster command headquarters.			
Our volunteer and staff teams have been assembled and are involved in providing disaster response services.			
We monitor all staff and volunteers for burnout and provide adequate respite when needed.			
We are able to assess and monitor the damage done to substance abuse prevention and treatment services.			
Our staff and volunteers provide ongoing substance abuse prevention support to other disaster workers and community members to help limit psychological effects of the disaster when possible.			
Staff volunteers who are unable to assemble due to lack of communication or involvement as victims of the disaster have backups who quickly assume necessary roles.			
We engage in ongoing reassessment of our plans based on information received and modify our plans accordingly.			
Recovery: Returning Systems to Normal We are able to activate policies and procedures to implement our plans.			
We constantly reassess the risk and resiliency of the communities in our State system and of the staff and volunteers necessary to provide the highest quality services.			
We use multiple prevention strategies with multiple audiences.			
We utilize mutual aid agreements.			
We set up services where the people are and streamline service application and delivery.			
We offer culturally sensitive services, with bilingual and bicultural providers to all communities as needed.			
We conduct ongoing assessment and followup studies to determine the effects of disasters on substance abuse problems, and to identify the prevention and treatment services that were the most effective.			
We conduct regular debriefing sessions with key staff and volunteers to gather "lessons learned" and improve our disaster service system.			
We have restructured the service system where necessary to be consistent with new parameters introduced by disaster's impact.			

The following checklist is intended to help community organizations assess their readiness in the areas of prevention planning for disasters.

Disaster Checklist for Community Substance Abuse Prevention Organizations	Yes	No	Needs Work
Preparedness: Lessening the Effects of a Disaster We have a well-developed disaster plan for substance abuse prevention services for the three phases of a disaster: preparedness, response, and recovery.			
Our plan is updated at least annually.			
We have contacted all State governmental organizations involved in disaster services and reviewed their roles as they affect our level.			
We have contacted all State-level nonprofit organizations involved in disaster services and reviewed their roles as they affect our level.			
We have contacted all national governmental organizations involved in disaster services and reviewed their roles as they affect our level.			
We have contacted all national nonprofit organizations involved in disaster services and reviewed their roles as they affect our level.			
We have contacted local governmental organizations involved in disaster services and reviewed their roles.			
We have contacted local nonprofit organizations involved in disaster services and reviewed their roles.			
We have involved key stakeholders in the development of our plan.			
Our disaster plan is integrated with the State substance abuse disaster plan.			
Our plan is integrated with the local community office designated to coordinate disaster services.			
We have identified and resolved all "turf"/jurisdictional issues with other organizations involved in disaster services.			
We have educated other organizations and government leaders about the role of substance abuse prevention in disaster planning and services.			
We have developed baseline data for our community on substance abuse problems that will be needed for disaster recovery funding.			
We have identified the probable services that will be needed for substance abuse prevention and treatment during all phases of a disaster.			
We have identified all potential sources of disaster-related funding to provide substance abuse prevention services.			
We have created relationships with sources of funding, obtained necessary application materials, and drafted applications to the extent possible in preparation for a disaster.			
We have reviewed State policies and procedures for grants and contracts to provide substance abuse prevention and treatment services during the response and recovery phases.			
We have prenegotiated policies and procedures for units of service and reimbursement rates for substance abuse prevention and treatment services that may be needed during the response and recovery phases.			

Disaster Checklist for Community Substance Abuse Prevention Organizations (Continued)	Yes	No	Needs Work
We have identified the various roles of substance abuse prevention and treatment staff and volunteers for all phases of a disaster and defined responsibilities and experience levels needed for each role.			
We have provided training to all substance abuse prevention and treatment staff and volunteers on basic disaster response services, preparation required for disaster work, and prevention and treatment services needed in a disaster.			
We have provided training to other key disaster services staff and volunteers on the role of substance abuse prevention and treatment services during a disaster.			
We have issued guidelines for staff and volunteers about needed medical preparation, e.g., tetanus and other vaccinations, as may be required.			
We have identified bicultural and bilingual staff and volunteers for all cultural and linguistic groups within our community.			
We have identified and obtained equipment and supplies that we will need for our staff and volunteers during a disaster (radios, first aid kits, mobile housing, vehicles, etc.).			
We have contacted our State substance abuse authority for acquisition of equipment and supplies from Department of Defense facilities that are closing.			
We have arranged emergency housing resources, cash disbursement, and reimbursement policies and procedures for staff and volunteers.			
We have developed a system for checking the credentials of staff and volunteers and obtained identification that will be accepted by all disaster relief personnel.			
We have developed a system for notifying and assigning staff and volunteers in the event of a disaster that has multiple forms of communication in the event normal communication channels are disrupted.			
We have developed promising approaches for disaster-related prevention services, trained providers, and assembled the necessary supplies, equipment, literature, etc.			
We have established protocols for addressing substance users whose supplies are interrupted by a disaster and people who may misuse prescription medications, etc.			
We have worked with the SSA and the State Prevention Coordinator to develop or obtain public service announcements and educational materials for specific substance abuse prevention and treatment issues during a disaster.			
We have arranged for distribution and use of public service announcements and educational materials in the event of a disaster.			
We have arranged for alternative temporary service delivery sites to be in operation for response and recovery phases.			
We have created mutual aid agreements statewide among our substance abuse prevention and treatment providers during a disaster.			
We have identified local community policy and norms that affect disaster-related substance abuse prevention and treatment providers during a disaster.			

Disaster Checklist for Community Substance Abuse Prevention Organizations (Continued)	Yes	No	Needs Work
We have developed backup systems for all records to ensure that information will be protected during a disaster.			
We have identified community "gatekeepers" and provided training in helping skills and problem identification and referral skills.			
We hold simulations to test and practice our disaster plans and systems at least once every 6 months.			
Response: Providing Remedial Assistance We have established a headquarters for our substance abuse prevention and treatment service at the community central disaster command headquarters in cooperation with the SSA and State Prevention Coordinators.			
Our volunteer and staff teams have been assembled and are involved in providing disaster response services.			
We monitor all staff and volunteers for burnout and provide adequate respite when needed.			
We work with the SSA and State Prevention Coordinators to assess and monitor the damages to substance abuse prevention and treatment services.			
Our staff and volunteers provide ongoing support to other disaster workers and community members to help limit psychological effects of the disaster when possible.			
Staff and volunteers who are unable to assemble due to lack of communication or involvement as victims of the disaster have backups who quickly assume necessary roles.			
We engage in ongoing reassessment of our plans based on information received and modify our plans accordingly.			
Recovery: Returning Systems to Normal We are able to activate policies and procedures to implement our plans.			
We constantly reassess the risk and resiliency of community members, the community as a whole, and our staff and volunteers necessary to provide the highest quality services.			
We use multiple prevention strategies with multiple audiences.			
We utilize mutual aid agreements.			
We set up services where the people are and streamline service application and delivery.			
We offer culturally sensitive services, with bilingual and bicultural providers to all community members as needed.			
We conduct ongoing assessment and followup studies to determine the effects of disasters on substance abuse problems in our community and to identify the prevention and treatment services that were the most effective.			
We conduct regular debriefing sessions with key staff and volunteers to gather "lessons learned" and improve our disaster service system.			
We have reviewed State policies and procedures for provider grants and contracts and modified them to allow for the provision of prevention and treatment services during all phases of a disaster.			

Appendix
Theoretical Models and Approaches for Understanding and Addressing Substance Abuse Issues in Disasters

This section presents several mental health and social theory models, some with specific applicability to disasters, others related to substance abuse issues that can be used to understand the concepts involved in disaster-related substance abuse prevention. Two of the broader models are based on Abraham Maslow's Hierarchy of Needs and on Burgess and Baldwin's understanding of stress created by trauma. A third model is based on a public health approach to substance abuse problems. These models, whether applied separately or together, offer preventionists useful frameworks for understanding disaster-related substance abuse issues.

I. Abraham Maslow: Hierarchy of Needs

Abraham Maslow's Hierarchy of Needs (Maslow 1968) usually is depicted as a pyramid divided horizontally into five levels. These levels are illustrated in Figure 2. The five levels of needs are

Level 1—Physiological needs such as food, water, good health, oxygen, protection from the extremes of heat and cold;

Level 2—Security needs such as a physically safe environment;

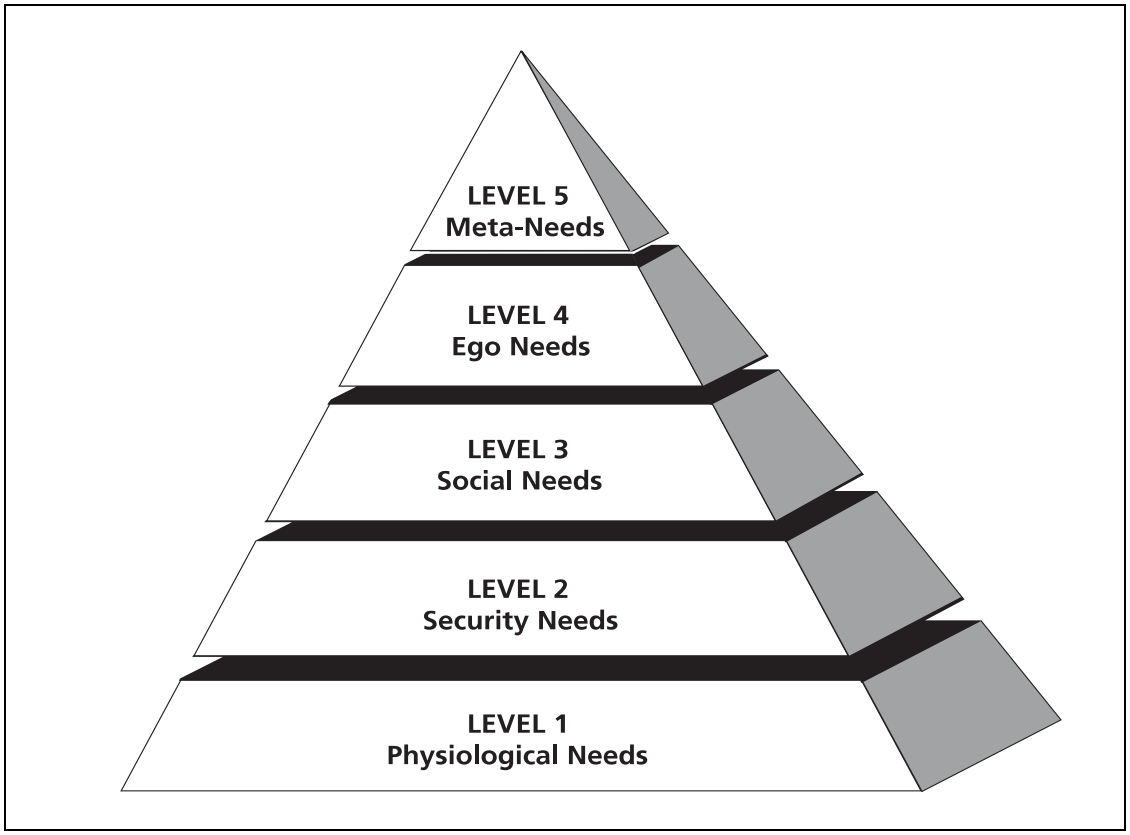
Level 3—Social needs include the ability to love, be loved, and be accepted as part of a social group;

Level 4—Ego needs such as those met through productive work and having a purpose in life;

Level 5—"Meta-needs," explained by Maslow to be the highest attainable level of need fulfillment, also called the stage of "self-actualization."

Each higher level of needs builds on the fulfillment of the ones below, but lower levels need not be met completely before the individual can begin to experience the next level of needs.

Figure 2. Maslow's Hierarchy of Needs



When a disaster destroys personal and community infrastructures, peoples' ability to meet their basic needs is disrupted. Maslow's Hierarchy can be used as a reminder to preventionists that their first priority in a disaster will be addressing the lowest level of survival needs. For example, finding clean, safe water supplies and food often becomes a very stressful task because the environment in which survivors find themselves is rarely safe, familiar, or secure. In addition, unforeseen aftereffects (e.g., fires, floods, looting, and panic) may add to the already stressful experience. The resulting trauma limits the individual's reliance on preexisting survival strategies, at least initially.

II. Burgess and Baldwin: Traumatic Stress

Dr. Paula Gordon, a former consultant with the National Preparedness Directorate of the Federal Emergency Management Agency, suggests that the work of Burgess and Baldwin (1981), which deals with traumatic crises in general, also can be used to understand the relationship between disasters and the stress felt by individuals, families, and communities. These stressors may lead to increased substance abuse problems for some people in a disaster area.

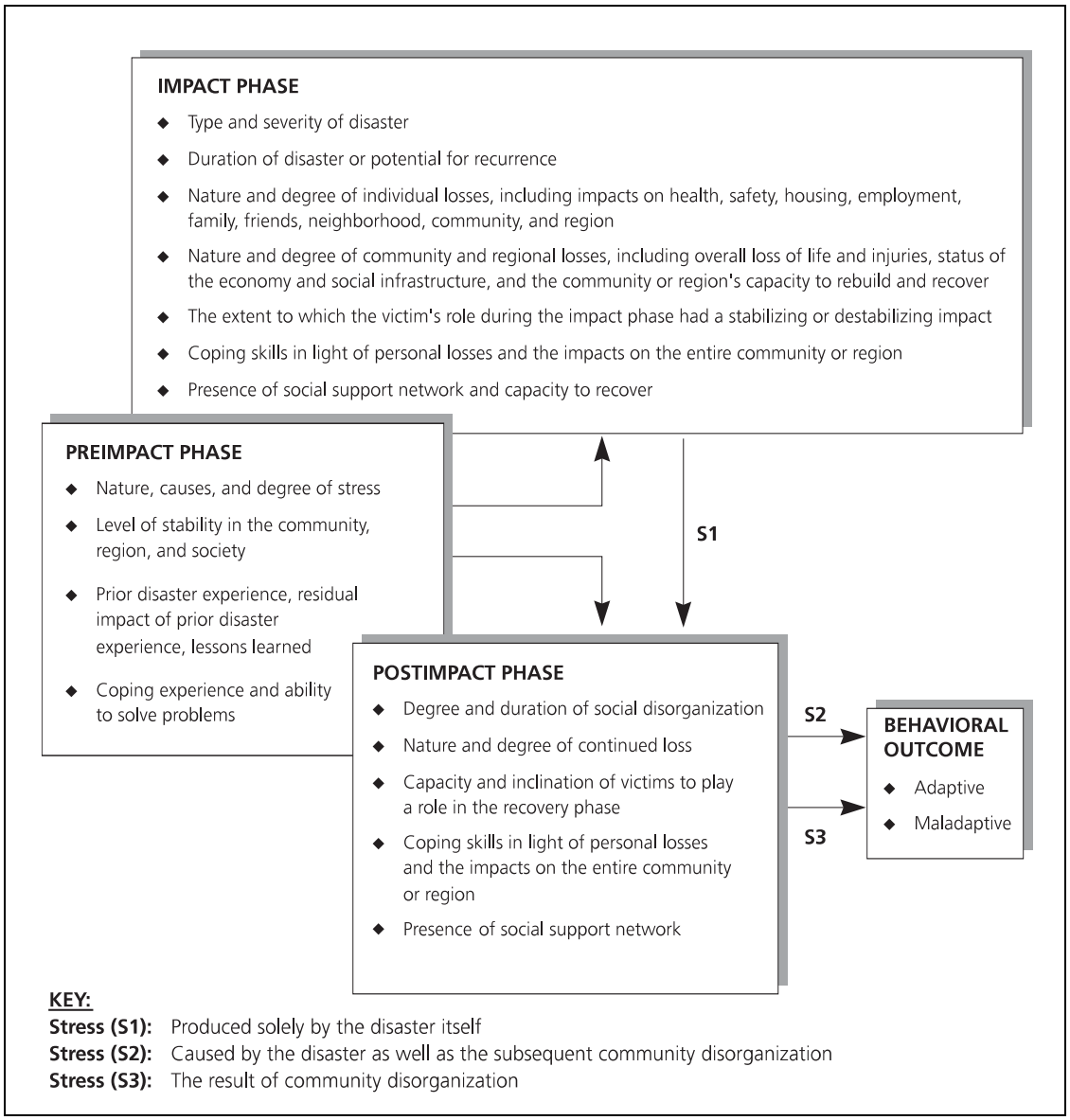
These stressors develop in three phases:

- **The Preimpact Phase:** Focuses on influences predating the disaster that affect normal stress levels.

- ✎ **The Impact Phase:** The disaster strikes, and new stressors are created that build on existing stress.
- ✎ **The Postimpact Phase:** The period that follows the disaster, lasting from 3 months to 3 years, is the most complex. Stress factors present before the disaster, stress caused by the disaster itself, and stress from community devastation and chaos accumulate to influence personal and community health.

These phases are interlinked, as depicted in Figure 3, which expands the Burgess and Baldwin model to illustrate how the disaster itself (impact phase) can have serious repercussions (postimpact phase) that can accentuate previous stress factors (preimpact phase). All three phases must be taken into consideration to understand the impact a disaster can have on behavior.

Figure 3. The Interconnected Nature of the Three Phases Influencing Disaster-Related Behavior



Substance Abuse Prevention in Declared Disasters: A Range of Possible State/Territorial Approaches

Table 5, developed by Dr. Paula Gordon using Burgess and Baldwin's work, presents the options for States and Territories to consider in establishing policies and goals for providing substance abuse prevention services in areas affected by declared disasters. Each row of the matrix introduces an issue to be addressed through the State's policy. The columns show how the State's policy may vary depending on the extent of effort it is willing or able to put forth.

For example, the first row of the matrix deals with the basic goals of State authorities' disaster-related efforts. The "Minimal" column lists only information dissemination, representing a minimal goal for State or Territorial authorities' disaster-related efforts. The "Midrange" column lists a few additional activities. The "Optimal" column details the goals that would represent a comprehensive approach to disaster-related substance abuse prevention. Optimal goals presume an adequate mandate and sufficient resources. Since there has been no opportunity yet to test the levels of effort presented here, the levels are based on theory and accepted substance abuse prevention practices.

Table 5. A Range of Possible State/Territorial Approaches

	Minimal Level of Effort (Hypothetical approach—not being advocated)	**Midrange Level of Effort** (Hypothetical approach—not a comprehensive approach and not presented as an exemplary approach)	**Optimal Level of Effort** (Presented as a prescriptive, comprehensive approach to disaster-related substance abuse problem prevention)
A. Basic Goals: State and Territorial Substance Abuse Authorities	Information dissemination Some outreach efforts	Some referral to services Some community-based programs Approach that addresses unmet needs and underlying causes	Restoration and revitalization of the community Individual, family, and community health and stability
B. Understanding of Disaster and Disaster Preparedness	Focus on understanding of near-term impacts Focus on response	Moderate understanding of near-term/long-term impacts Moderate understanding of disaster preparedness, response, and recovery	Optimal level of understanding of near-term/long-term impacts Optimal level of understanding of disaster preparedness, response, and recovery Complete understanding of causative factors leading to improvement in disaster-related substance abuse prevention Learning from best practices and lessons learned

Table 5. A Range of Possible State/Territorial Approaches (Continued)

	Minimal Level of Effort (Hypothetical approach—not being advocated)	**Midrange Level of Effort** (Hypothetical approach—not a comprehensive approach and not presented as an exemplary approach)	**Optimal Level of Effort** (Presented as a prescriptive, comprehensive approach to disaster-related substance abuse problem prevention)
C. Understanding Related To Mental Health: Nature of Understanding of the Influences on Disaster-Related Mental Health and Substance Abuse-Related Problems and Nature of Emphasis on Mental Health and Social Services	Some recognition of increase in substance abuse Minimal emphasis on coordination with mental health and social services	Greater recognition of increase in substance abuse and that this increase accompanies an upsurge in stress-related behavior generally Emphasis on coordination with mental health and social services Qualitative methods of assessment	Understanding the context for increase in substance abuse Qualitative and quantitative assessments in establishing case for funding Emphasis on coordination with mental health and social services from national, local, State, and Federal organizations
D. Approach To Substance Abuse Prevention: Nature of Emphasis on Substance Abuse Prevention in the Aftermath of a Disaster	Traditional approaches to substance abuse-related information dissemination Minimal emphasis on culturally and linguistically appropriate information and information dissemination Reactive focus solely on relief and recovery Focus on an array of materials: ✎ Information sheets ✎ Kinds of reactions to expect in the aftermath of a disaster ✎ Information "do's and don'ts" ✎ Public service announcements ✎ Resource contact lists	Broader approaches to substance abuse prevention Some attention to community renewal and promotion of individual, family, and community health and stability Some referral to services with attention to culturally and linguistically appropriate approaches to information dissemination, and technical assistance/training Greater attention to preparedness Greater array of materials: ✎ Information sheets ✎ Kinds of reactions to expect in the aftermath of a disaster ✎ Information "do's and don'ts" ✎ Public service announcements ✎ Resource contact lists ✎ *Guide* and other materials produced by communities, governmental, or national organizations for use by community organizations, families, and individuals	Broadest approach to substance abuse prevention Emphasis on maintenance, restoration, and promotion of individual, family, and community health and stability Understanding that materials are part of a well-defined context that includes extensive technical assistance, training, and education

Table 5. A Range of Possible State/Territorial Approaches (Continued)

	Minimal Level of Effort (Hypothetical approach—not being advocated)	**Midrange Level of Effort** (Hypothetical approach—not a comprehensive approach and not presented as an exemplary approach)	**Optimal Level of Effort** (Presented as a prescriptive, comprehensive approach to disaster-related substance abuse problem prevention)
E. Funding: Approaches to Funding and Funding-Related Issues	A conduit for substance abuse-related information dissemination Minimally defined and communicated information concerning the availability and requirements for funding	Broader range of activities, programs, policies, and approaches Coordination with Federal agencies Some technical assistance provided to communities Resources provided to community-based organizations Information and requirements regarding funding and purposes served by funding Emphasis on information and information dissemination	Coordination with Federal agencies, American Red Cross, and other local, State, and national organizations to provide services and technical assistance Coordination with similar agencies and community-based organizations successful in disaster-related substance abuse prevention Reorientation of prevention efforts Clear communication of information and requirements concerning availability of funding Reorientation of approaches to funding Reduction in red tape Steady funding on long-term recovery efforts Provision of adequate funding for preparedness efforts

Table 5. A Range of Possible State/Territorial Approaches (Continued)

	Minimal Level of Effort (Hypothetical approach—not being advocated)	**Midrange Level of Effort** (Hypothetical approach—not a comprehensive approach and not presented as an exemplary approach)	**Optimal Level of Effort** (Presented as a prescriptive, comprehensive approach to disaster-related substance abuse problem prevention)
F. Activities: Range of Activities, Programs, Policies, and Approaches Emphasized	Information dissemination through printed materials and media public service announcements Technical assistance to help organizations develop and disseminate disaster-related substance abuse prevention information Grants to community-based programs Minimal emphasis on personal contact Minimal direct technical assistance Minimal attention to improving networking, coordination, and collaboration skills	Outreach and referral services Attention to community restoration and revitalization Promotion of individual, family, and community health and stability Proactive approaches Direct person-to-person contact Direct technical assistance Networking and collaboration of key players in development of activities, programs, policies, and approaches	Person-to-person contact Comprehensive approach to helping communities in restoration and recovery efforts Promotion of individual, family, and community health and stability as part of substance abuse prevention efforts Development of strategies for using volunteers, professionals, and others to provide services Enhanced networking and mobilizing resources Extensive direct technical assistance, education, and training Full range of activities Approaches for children, youth, parents, elderly, infirm, and culturally/ethnically diverse populations Counseling, hotlines, support groups, and other support networks
G. Key Players: Key Players That Would Be Involved	FEMA American Red Cross Community organizations Media	SAMHSA/CSAP/CSAT/CMHS FEMA National disaster-related organizations, including the American Red Cross State and Territorial offices of emergency services Community organizations Media	SAMHSA/CSAP/CSAT/CMHS FEMA and other Federal agencies American Red Cross, Salvation Army, National Volunteer Organizations Active in Disasters, and other State and national organizations State and Territorial offices of emergency services Community organizations, including partnership grantees and coalitions Media

Table 5. A Range of Possible State/Territorial Approaches (Continued)

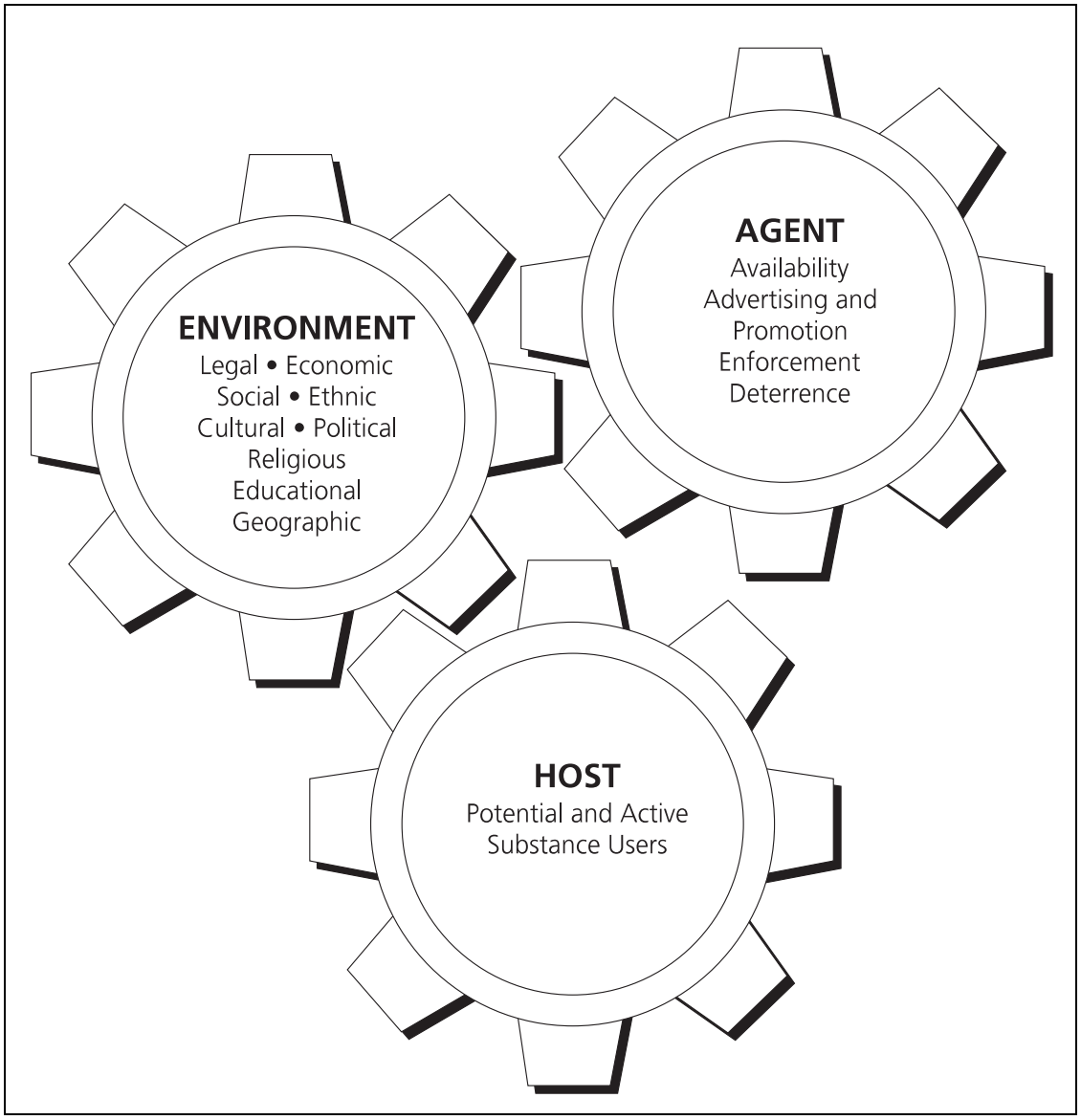
	Minimal Level of Effort (Hypothetical approach—not being advocated)	**Midrange Level of Effort** (Hypothetical approach—not a comprehensive approach and not presented as an exemplary approach)	**Optimal Level of Effort** (Presented as a prescriptive, comprehensive approach to disaster-related substance abuse problem prevention)
H. Information/ Educational Approaches: Information or Resources Packages Provided or Fostered by SAMHSA/CSAP and Others	Information sheets of reactions to expect in the aftermath of a disaster Information sheets on "do's and don'ts" Public service announcements Resource contact lists	Information sheets of reactions to expect in the aftermath of a disaster Information sheets on "do's and don'ts" Public service announcements Resource contact lists Manuals and other materials produced by communities, States, or national organizations Technical assistance, education, and training	Guidance materials on the range of preparedness and recovery efforts that community-based organizations can undertake Informational materials concerning disaster-related substance abuse prevention Training materials for volunteers and service providers Technical assistance Materials on effective or promising programs and policies
I. Technical Assistance and Training: State and Territorial Agency Emphasis on Technical Assistance, Training, and Capacity Building	Focus primarily on information dissemination and public service announcements Some funding for capacity building	Technical assistance, training, and capacity-building efforts Technical assistance and action teams in the aftermath of a disaster Some teleconferencing for technical assistance expertise	Broad technical assistance, education, training, and capacity building Focus on programs and activities for victims to help themselves, others, and the community Technical assistance, education, training, and capacity-building efforts for local and State structures Sensitivity to the needs, perspectives, and inclinations of communities and community-based organizations

III. The Public Health Approach

One framework used effectively for many years to view and address the prevention of substance abuse is the public health model. This model recognizes that prevention is a dynamic process and focuses on three elements: the agent, the host, and the environment.

This model is especially relevant for viewing a prevention response before and after a disaster. Figure 4 describes this model as it relates to disaster.

Figure 4. Targets of a Disaster Response Using the Public Health Model



The Agent

The agent is defined as alcohol, tobacco, or drugs. Prevention strategies that focus on the agent are aimed at reducing the supply of these substances. Specific strategies directed toward the agent that have particular relevance for disaster work include

- ✎ Availability considerations,
- ✎ Advertising and promotion,
- ✎ Enforcement, and
- ✎ Deterrence.

Availability Considerations

Changes in the consumption of alcohol, tobacco, and drugs in the aftermath of a disaster may be difficult to predict. In some cases, new drugs may become available as workers and others enter the area in large numbers to provide shelter and other services.

Advertising and Promotion

Communities should have prior agreements with media, vendors, and other alcohol and tobacco advertising and promotional agents to restrict the advertising and promotion of alcohol and tobacco in the aftermath of a disaster.

Enforcement

Communities can consider developing and enforcing local ordinances that address the issue of sales of alcohol following a disaster.

Deterrence

Law enforcement officers can play an important role and should be educated and trained in advance to cope with possible postdisaster substance abuse.

The Host

The term "host" covers potential and active alcohol, tobacco, and drug users; their particular susceptibilities to alcohol, tobacco, and drug problems; and knowledge and attitudes that influence their substance use problem behavior. Individuals use alcohol, tobacco, and drugs for a number of complex biological, environmental, and psychosocial reasons. This model is based on the premise that these factors can be greatly exacerbated during periods of stress such as a disaster.

Disaster-related environmental and psychosocial impacts that increase risk for the host include

- ✎ Grief caused by loss of loved ones and possessions;
- ✎ Trauma resulting from the need to relocate home, school, or job;
- ✎ Uncomfortable living arrangements;
- ✎ Inability to communicate with the outside world; and
- ✎ Loss of television, radio, and other forms of entertainment.

The Environment

The environment is defined as the climate that encourages, discourages, reinforces, or sustains the problematic use of alcohol, tobacco, and drugs. The environment also includes specific institutions and systems such as schools, religious institutions, the community in which they exist, and society and its norms and mores.

In summary, alcohol, tobacco, and drug use is influenced by a variety of environmental factors, such as the legal, economic, financial, and social environments. Other important influences are cultural, political, geographic, religious, ethnic, and educational factors.

The following discussion highlights environmental approaches and risk and protective factors derived from the public health model.

Environmental Approaches

In recent years, there has been a growing awareness of the degree to which the larger environment affects alcohol, tobacco, and drug use, misuse, and abuse. In fact, some of the most powerful prevention strategies occur at the level of the community, State, or national environment. In the same way, many of the alcohol- and drug-related problems that may occur in conjunction with a disaster can be prevented or reduced by changing or controlling the community environment.

Environmental factors affecting alcohol, tobacco, and drug use and related problems are usually seen as including

- ✎ Price and availability,
- ✎ State or local policies regarding availability and use, and
- ✎ Community norms regarding use.

Under normal circumstances, each of these factors can have a profound effect on the ways people use alcohol, tobacco, and drugs and the problems related to their use. For example, the number of liquor outlets, their locations, their hours of sale, and their pricing and promotional practices can all affect the amount of alcohol sold and consumed in a community and the level of such problems as liver cirrhosis and alcohol-related traffic crashes (Holder 1993). The existence and enforcement of laws and policies regarding sales of alcohol and tobacco to minors can dramatically affect the amount of these substances used by young people and the consequent problems (Sweedler 1990). Expressions of community norms about the use of alcohol and tobacco, as expressed by such things as advertising in the community and promotion and availability of alcohol and tobacco at community-sponsored events, may also have an effect on use and problems.

During and after a disaster, these environmental factors may be disrupted dramatically. Some types of disruption may reduce use. For example, supplies of alcohol, tobacco, and drugs may be reduced immediately after a disaster while stores are closed or dealers are unavailable. Other types of disruption may increase availability to some populations. For example, laws against sales to minors may not be enforced while police are busy dealing with the disaster aftermath. Similarly, the usual social norms concerning the appropriate contexts for the use of alcohol, tobacco, and drugs may be disrupted during periods of social disorganization.

It is extremely important to plan for careful controls on environmental factors during and after disasters, especially with regard to alcohol. Many of the most negative and destructive social consequences of disasters—looting, family violence, and other crimes—are often fueled by alcohol. It is imperative that carefully planned controls go into effect immediately to ameliorate these problems.

Controlling Availability

- ✎ Availability of alcohol can be reduced by limiting the hours of sale of alcohol. In emergency situations, it may be necessary to close alcohol outlets altogether. The imposition of curfews can also limit availability of alcohol as well as drugs.

- ✎ The general willingness to work for the good of society that is often apparent after a disaster should be extended to include concerns about alcohol-related problems. An awareness campaign directed at alcohol sales establishments can enlist the help of these establishments in maintaining public order by avoiding sales to minors or to intoxicated persons.

Policies Regarding Availability and Use

- ✎ The disruption that occurs in the wake of a disaster should not be allowed to eliminate or weaken enforcement of laws and policies related to alcohol and drugs.
- ✎ Policies should be established to strictly control the use of alcohol and drugs in emergency shelters.

Community Norms Regarding Use

In the aftermath of a disaster it is important to express community norms regarding responsible use of alcohol and nonuse of illicit drugs. The voluntary controls on availability as well as continued enforcement of laws and policies help to express these norms. A public awareness campaign, including billboards and radio broadcasts targeted to those most affected by the disaster and directly addressing disaster-related substance abuse, could reinforce community norms in a time of uncertainty and stress. Such a campaign could be prepared as part of disaster planning for rapid implementation.

Risk and Protective Factors

In recent years, much of the work of prevention has been organized using a framework of what are called risk and protective factors. These factors have emerged from research that shows a correlation between a variety of factors and later substance abuse problems. The research has not always proven that risk factors cause individuals to have substance abuse problems or that protective factors prevent these problems. However, the association is strong enough to lead preventionists to believe that reducing risk factors and enhancing protective factors may decrease substance abuse. Commonly cited substance abuse risk factors occur in several domains:

- ✎ Availability (see previous discussion);
- ✎ Laws and norms controlling price, availability, and circumstances of use (see previous discussion);
- ✎ Family factors, including patterns of drug use in the family, family management practices, conflict, and bonding;
- ✎ School factors, including academic failure, low commitment to school, and rejection by classmates in elementary school;
- ✎ Peer factors, including association with drug-using peers and with those who have favorable attitudes toward drug use;
- ✎ Individual problems, such as genetic and biochemical predispositions, and the presence of early and persistent problem behaviors; and
- ✎ Community characteristics, including level of poverty and social disorganization.

Ongoing prevention approaches that reduce risk factors and enhance protective factors in all of the domains may be helpful in insulating against postdisaster substance abuse. In addition, the occurrence of disasters might affect some of these risk and protective factors, at least on a temporary basis. Communities might become more disorganized; family conflict might increase; and availability of alcohol, tobacco, and drugs might change. Research does not indicate the extent to which these temporary changes might have an impact on long-term risks for use of these substances or on the development of related problems.

Because of the conceptual utility of this framework, prevention planners and practitioners may wish to incorporate some aspects of the risk and protective factors into disaster planning and response. Areas that might be particularly relevant include

- **Family factors—**Some family risk factors can be exacerbated during and after disasters, and family protective factors may be impaired. Family conflict may increase; parental discipline practices may be weakened; and use of alcohol and drugs by parents may increase or may occur more frequently in situations where children are exposed to it.
- **School factors—**School schedules often are disrupted by disasters. In addition, such problems as stress, family difficulties, and the need to spend more time and energy on basic needs may make concentration on school more difficult. Thus, academic success and bonding to school may be disrupted by disasters. Strategies for dealing with these problems are discussed in the section on prevention strategies in schools in Chapter 4, "Disaster Recovery."
- **Peer factors—**Normal peer relationships may be disrupted by a disaster when schools are closed, friends are injured or killed, and families are relocated. Thus, there is the danger that the protection afforded by healthy relationships with prosocial peers might be disrupted or that contact with peers who use drugs or who have positive attitudes toward drugs might increase. Strategies for enhancing positive peer relationships include involving youth in prosocial cleanup activities and disaster-related support groups.
- **Individual factors—**Disruption in the other domains (community, family, school, and peer) may lead to a variety of behavior problems, including early experimentation with alcohol, tobacco, and drugs. The availability of counseling and other support in the aftermath of disasters has been shown to decrease posttraumatic stress disorder symptoms among adolescents (Yule 1992). It is possible that concurrent or subsequent drug use might also be decreased, although no specific research is available on this aspect of responses to disaster.

Other research explores factors that may affect individual stress in response to a disaster. For example, people who were experiencing chronic stress prior to a disaster were found to have more long-term symptoms of stress following a disaster (Norris and Uhl 1993); and children and parents who were separated during or after a disaster showed greater symptoms of anxiety and stress than those who were able to remain together (McFarlane 1987). However, studies rarely examine substance abuse issues specifically. Therefore, this research may be more useful for guiding mental health efforts in general than for guiding substance abuse prevention.

Community Characteristics

Preventionists can encourage the development of positive community characteristics by helping communities focus on turning the situation around, and encouraging a sense of hope.

After the floods in Albany, Georgia (summer 1994), the city proposed designing new neighborhoods to replace the slum areas affected by floods, which also were neighborhoods with relatively high levels of substance abuse. City leaders are focused on "turning a negative into a positive." Planning meetings are continuing with local, State, and Federal Government officials in collaboration with civic, business, law enforcement, and community groups and coalitions from all socioeconomic levels to undertake rebuilding efforts. Some of the early outcomes are collaborative planning and project implementation for better housing units for low-income citizens, destruction of unsafe and abandoned commercial buildings, and local jobs on city rebuilding teams for some underemployed and unemployed citizens.

References

American Psychological Association. (1994*a*). DRN survey results. *Disaster Response News* 3(2):10–11.

American Psychological Association. (1994*b*). Ethical challenges on site of disasters. *Disaster Response News* 3(2):5–6.

Burgess, A.W., and Baldwin, B.A. (1981). *Crisis Intervention Theory and Practice: A Clinical Handbook.* Englewood Cliffs, NJ: Prentice Hall.

Center for Substance Abuse Prevention. (1993). *Alcohol, Tobacco, and Other Drugs Resource Guide: Faith Communities.* DHHS Pub. No. (ADM)93-1986; MS457. Rockville, MD: Center for Substance Abuse Prevention.

Gordon, N.S., and Maida, C.A. (1992). *The Immediate Community Response to Disaster: The East Bay House Fire.* Quick Response Research Report #51. Boulder, CO: University of Colorado, Institute of Behavioral Science, Natural Hazards Research and Applications Information Center.

Holder, H. (1993). Prevention of alcohol-involved traffic crashes. In: *Alcohol and Other Drugs in Transportation: Research Needs for the Next Decade.* Washington, DC: Transportation Research Board, pp. 85–105.

Maslow, A.H. (1968). *Toward a Psychology of Being,* 2nd ed. Princeton, NJ: Van Nostrand Co.

McFarlane, A.C. (1987). Posttraumatic phenomena in a longitudinal study of children following a natural disaster. *Journal of the American Academy of Child and Adolescent Psychiatry* 21(5):764–769.

National Institute of Mental Health. (1978). *Field Manual for Human Service Workers in Major Disasters.* DHHS Pub. No. (ADM)90-537. Rockville, MD: National Institute of Mental Health.

Norris, F.H., and Uhl, G.A. (1993). Chronic stress as a mediator of acute stress: The case of Hurricane Hugo. *Journal of Applied Social Psychology* 23(16):1263–1284.

Ofman, P.S. (1994). Licensing issues during out-of-state response: The APA/State board licensing project. *Disaster Response News* 3(2):8–9.

Points of Light Foundation. (n.d.). *Ready to Respond: A Disaster Preparedness Manual for Volunteer Centers.* Washington, DC: Points of Light Foundation.

Sweedler, B. (1990). Strategies to reduce youth drinking and driving. *Alcohol, Health and Research World* 14(1):76–80.

Yule, W. (1992). Post-traumatic stress disorder in child survivors of shipping disasters: The sinking of the "Jupiter." *Psychotherapy and Psychosomatics* 57(4):200–205.

DHHS Publication No. (SMA) 97-3123
Printed 1997